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OVERSIGHT OF THE VA'S EXTENDED CARE AND GERIATRIC PROGRAMS

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BEFORE THE

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HOSPITALS AND HEALTH CARE

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HOUSE OF REPRESENTATIVES

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CONTENTS

JULY 14, 1982

Page

Oversight of the VA's Extended Care and Geriatric Programs 1

STATEMENTS OF COMMITTEE MEMBERS

Chairman Mottl 1

Hon. John Paul Hammerschmidt 2

WITNESSES

Brinsky, Gabriel, National Service and Legislative Director, AMVETS 18
- Prepared statement of Mr. Brinsky 48

Custis, Dr. Donald L., M.D., Chief Medical Director, Department of Medicine and Surgery, Veterans' Administration, accompanied by Paul Haber, M.D., Assistant Chief Medical Director for Geriatrics and Extended Care; Ronald C. Crump, Office of The General Counsel; John Mather, Director, Affiliated Education Program Service; Frank A. Morrone, Director, Health Systems Information Service; and Barbara Pryor, Geriatrics Advisory Committee 3
- Prepared statement of Dr. Custis 29

Egan, Paul, deputy director, National Legislative Commission, and John Sommer, Jr., deputy director, National Veterans' Affairs and Rehabilitation Commission, the American Legion 21
- Prepared statement of the American Legion 81

Mansfield, Gordon, associate legislative director, Paralyzed Veterans of America 19
- Prepared statement of Mr. Mansfield 57

Schwab, Donald H., director, National Legislative Service, Veterans of Foreign Wars 23
- Prepared statement of Mr. Schwab 94

MATERIAL SUBMITTED FOR THE RECORD

Statements:
- American Academy of Ophthalmology 111
- American Optometric Association 116
- Veterans of World War I 121

OVERSIGHT OF THE VA'S EXTENDED CARE AND GERIATRIC PROGRAMS

WEDNESDAY, JULY 14, 1982

House of Representatives,
Subcommittee on Hospitals and Health Care,
Committee on Veterans' Affairs,
Washington, D.C.

The subcommittee met, pursuant to call, at 9 a.m., in room 334, Cannon House Office Building, Hon. Ronald M. Mottl (chairman of the subcommittee) presiding.

Present: Representatives Mottl, Daschle, Edgar, Hammerschmidt, Heckler, Hillis, McEwen, Dunn, Smith of New Jersey, and Smith of Alabama.

OPENING STATEMENT OF CHAIRMAN MOTTL

Mr. Mottl. Good morning. The subcommittee will come to order.

We are meeting this morning to continue this subcommittee's oversight of the VA's extended care and geriatric medical programs. This remains an issue of high importance to us, particularly in light of the warnings issued earlier this year by Administrator Robert Nimmo that the VA hospitals would soon be flooded with veterans over 65 years of age and tax VA's ability to deliver quality health care beyond its limits.

In 1975, the VA established the geriatric research, education, and clinical centers, GRECC's, in order to attract professionals to teach and conduct basic and clinical research on aging, to provide education in geriatrics, and to experiment with alternative means for providing care to the aged.

With the able and concerned efforts of our colleague from Massachusetts, the Honorable Margaret Heckler, language was included in Public Law 96-330, the Veterans' Administration Health Care Amendments of 1980, to authorize expansion of this program up to 15 GRECC's.

There are currently eight of these centers in operation, and we hope to learn today what the VA is doing in meeting the language of Public Law 96-330 in a positive manner.

Public Law 96-330 also required the establishment of a geriatric and gerontology advisory committee. During this subcommittee's last oversight hearing on this subject on July 22, 1981, it was learned that the committee has been established and given two basic charges:

First, they were to assess through an evaluation process, including site visits, the eight existing GRECC's; and second, they were to assess the capability of the VA to provide high-quality geriatric extended and other health care services to older veterans and the current and projected needs of those veterans for such care.

It has been a year since that last hearing; and I, along with Mrs. Heckler, who has worked so diligently on this matter, will be greatly interested in learning how this advisory committee and the Department of Medicine and Surgery has progressed.

The members of this subcommittee feel very strongly that a balanced long-term care program of multiple resources, in addition to a comprehensive acute care hospital program, is essential to meet the needs of the elderly veteran population.

To this end, we expect the VA to inform us of their total planning to meet the needs of the aging veteran in terms of direct hospital treatment, including intermediate care and nursing home care.

We hope that they will discuss this total planning to treat the elderly veteran without adversely affecting the quality health care the veteran population is now receiving.

Before we receive testimony from the VA and the service organizations, I would like to turn to the ranking minority member of the subcommittee, Hon. John Paul Hammerschmidt, for his opening comments.

STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

I know that as you later introduce VA witnesses you will be commending Dr. Paul Haber, and I may have to leave these hearings early, because I have two other subcommittees going at the same time, but I want to comment now on Dr. Paul Haber.

His contribution to the VA's medical program for the aging veteran are legend. Time and again in appearances before our committee, he has shown a remarkable skill and knowledge with respect to this subcommittee, and certainly he richly deserves his splendid reputation, and I join you in expressing appreciation for his efforts.

Mr. Chairman, we meet today to discuss a most important aspect of VA's medical program. The problem of the aging veteran is no longer one that is concerned with just the future. It is a problem that is upon us now, although certainly one that will intensify in the immediate years ahead.

Mr. Chairman, sometimes we hear the expression about long-term chronic medical needs of the aging as if these needs were separate and apart from the needs for acute care. The truth is that the aged veteran, while often needing long-term hospitalization, is also very likely to have recurring episodes of acute care.

VA thus needs a balanced approach which does not sacrifice one for the other. I am confident our principal witness this morning, Dr. Custis, would agree.

Mr. Chairman, the subject of geriatric research and critical care centers is on the agenda today. In this connection, you will recall when we sent our report to the House Budget Committee with respect to the President's budget request for 1983, we noted that only 8 of an authorized 15 GRECC's were in existence.

We urged early action to increase that number. I would hope Dr. Custis, in his testimony, will address the question of such an increase.

Mr. Chairman, the subject of State hospitals is also on the agenda. In my opinion, this is an excellent program of Federal-State relationships, and I am pleased to note that Dr. Custis plans to discuss that, also.

Mr. Chairman, you have commended our colleague, Mrs. Heckler, for her work in the field of geriatric medicine within the Veterans' Administration. I certainly want to join with you in that commendation, which is very much deserved.

Thank you, Mr. Chairman.

Mr. **Mottl**. Thank you, very much, Mr. Hammerschmidt.

Our first witness today is Dr. Donald Custis, the Chief Medical Director of the Veterans' Administration.

Before you present your testimony, Dr. Custis, I want to recognize your colleague, along with my distinguished colleague from Arkansas, Dr. Paul Haber, the Assistant Chief Medical Director for Extended Care.

Dr. Haber, we want to welcome you and to recognize the many contributions you have made to the planning and implementation of the medical care program for the aging veteran. Your dedication reflects great credit to the Veterans' Administration, and to you personally.

As chairman of the Subcommittee on Hospitals and Health Care, I want to commend you for your outstanding efforts on behalf of the American veteran.

Dr. Custis, you may proceed with your testimony, and your entire statement will be included in the record, without objection, and you may proceed as you deem fit.

It is nice having you with us again. I want to also add to the accolades of Dr. Paul Haber, meaning accolades of Dr. Donald Custis. I feel you have done an outstanding job for the American veteran. You have been shackled somewhat, but, notwithstanding those limitations, I want to commend you for your great work.

Dr. Custis, welcome. It is a pleasure to have you here this morning.

STATEMENT OF DONALD L. CUSTIS, M.D., CHIEF MEDICAL DIRECTOR, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION, ACCOMPANIED BY PAUL HABER, M.D., ASSISTANT CHIEF MEDICAL DIRECTOR FOR GERIATRICS AND EXTENDED CARE; RONALD C. CRUMP, OFFICE OF THE GENERAL COUNSEL; JOHN MATHER, DIRECTOR, AFFILIATED EDUCATION PROGRAMS SERVICE; FRANK A. MORRONE, DIRECTOR, HEALTH SYSTEMS INFORMATION SERVICE; AND BARBARA PRYOR, GERIATRICS ADVISORY COMMITTEE

Dr. **Custis**. Good morning, Mr. Chairman, and members of the committee. Thank you for those kind words. All of us here certainly join you in the expression of appreciation for the fine contributions of Dr. Haber.

Mr. Chairman, the opportunity to discuss the Veterans' Administration programs for delivering care to older veterans and to consider some of our thoughts about a predictable future in which the number of older veterans is bound to increase is both welcome and necessary.

With me this morning at the table are Mr. Cary Crump of the General Counsel's Office; Dr. John Mather of the Academic Affairs Office; Dr. Haber; and Mr. Frank Morrone, the Director of our Planning Office.

Also behind us is Ms. Barbara Pryor, who has been very ably serving as staff to the congressionally mandated Geriatrics Advisory Committee. You may wish to hear some of her contributions, too.

The number of veterans, Mr. Chairman, over the age of 65 is said to be 3.3 million in 1981, and it is projected to increase to 7.7 million in 1990, and to 9 million in the year 2000.

Expressed as percentage of the total veteran population, the comparable figures for these same years are 11, 27, and 34 percent, respectively.

In 1981, some 798,000 of the 3.3 million veterans over the age of 65 came to the VA for one form of care or another. That represents nearly 25 percent of that group. It seems to me that the lowest common denominator of prudence requires we should plan for about 1.8 million of the 7.7 million in 1980, and 2.2 million of the 9 million in the year 2000.

I think that the proportion of project users or would-be users of the VA health care system within the total pool of over-65-year-old veterans is likely to be somewhat greater than that.

I believe this is so because increases in medicare deductibles and coinsurance and reductions in medicaid funding will make the VA more economically attractive or even necessary to the future population pool than it was to the 1981 population pool.

We are beginning to experience this problem on a geographically limited basis, where cuts in medicaid funding have already produced locally observable increases in demand for care.

No one can say exactly at what point, by income levels, the balance of the economic desirability or necessary tilts in the direction of VA care for the veteran.

With or without these imponderables, however, it is clear that a crunch is in prospect, but that crunch cannot be met by simplistic, if well-intentioned, decrements to the rest of our health care system.

My views on this are based upon professional judgment and a consideration of public policy. If quality of care is seriously diminished and if we have less than a completely integrated and comprehensive system, we will have an inoperable system altogether.

Let me be more specific. A system that reduces acute care in order to provide other kinds of care needed by an aging population is reducing the kind of care that the aged also need, need more than others and more frequently than others.

A system that reduces this particular kind of care skews the patient population to a point where our affiliations with health professions schools are no longer viable and thus undermines our major guarantor of quality and our principal professional recruitment and retention device.

If this sounds familiar as an argument, it is. It is the same argument that we have been making against "mainstreaming" proposals—that, by taking away acute care, they would leave us with a system that was no longer viable as a system.

This much, it seems to me, sets the context for the overall approach to these problems. My full statement, submitted for the record, references our many current programs for the care of the aged and some near-term modifications planned for them.

It is our belief that we have already achieved a position of national leadership, both in geriatrics and gerontology. In this abbreviated summary, I should like to touch on two items, one that goes well beyond the VA's plans, per se, and the other having to do with our geriatric research, education, and clinical care centers.

As to the first of these, I should like to put forward what I believe could be a new approach to VA-community interaction. It is based on the evident fact that all the statistics I have cited to you, confined as they are to veterans as actual and potential patients in the system, may seem to bypass the fact that America is graying.

The issue of an aging population, and what means exist or must be created to deal with it, creates a set of problems, not just for the VA, but for society as a whole.

It seems to me that we must begin to work with communities all over this country in a variety of ways that recognize that we are a part of the problem—albeit a large part, with an estimate that 60 percent of all males over 65 in 1990 will be veterans.

It should follow, then, that we are only a part of the solution. I think we should, on a local basis, begin to participate in the creation of structures to deal with overall problems of an aging population, many of whom are veterans, so that we can work together with the communities to get the best "bang for both their bucks" and ours.

We have recently launched, within the Department of Medicine and Surgery, a medical district initiated program planning [MEDIPP] process which will increasingly rely on planning that comes up to the center from the grassroots.

Through this and other means, we want to encourage the growth of such cooperative community considerations on the local level, the initiation of experiments along these lines, and the search for valid interlocutors in the communities where we are located.

It may be, if we succeed in starting and nurturing the growth of such VA-community interactive structures, that both the VA facilities and the communities in which they are located can accomplish more with existing and additional resources than each of us is now doing or can anticipate doing alone.

With respect to the GRECC's, the full statement submitted to you for the record sets forth the history of their launching, and of congressional interest and support, and details some current accomplishments.

I should like to turn now to an expression of some opinions I have about their future development. I believe if we are going to make the most of them, we should be in a position to direct their operations on a basis that will play to the strength of the GRECC's, the facilities of which they are a part, and the larger professional community where those facilities are located. In order to make this happen, I am convinced we must be granted more flexibility in managing these centers.

In their current, somewhat rigidly defined state, they are most effective, in fact very effective, in research and in education, neither of which is unimportant to us, but less effective in affecting the delivery of care, which is no less important to us.

We will be expecting them to increase their role in direct patient care. An excellent start has been made in this direction. Six GRECC's have developed geriatric evaluation units, with a broad base in general internal medicine and in psychiatry, the latter with an emphasis on the treatment of Alzheimer's Disease.

Equally and importantly, clinical units with special emphasis on geriatrics are being developed in VAMC's which do not include GRECC's.

In summary, Mr. Chairman, I believe we are launched upon a good and productive course with the GRECC's, but the time has come to expand their numbers and their potential to act as a "leaven for the loaf" of our entire health care system's ability to care for the aged veterans, and that we need enough leeway and resources to follow through on that course.

I regret I will have to leave the hearing early this morning, and will not be able to hear the veterans' service organization testimony. I assure you and them I will read their statements on this important subject.

I thank you, Mr. Chairman. We would be happy to receive questions.

Mr. MOTTL. Thank you, Dr. Custis. We appreciate your fine statement this morning.

[The full statement of Dr. Custis appears on p. 29.]

Mr. MOTTL. We will invoke the 5-minute rule on questioning here. As you duly note, Public Law 96-330 authorized expansion of the GRECC program to 15 centers, but you also note that resources have not been forthcoming to realize this expansion.

Could you explain to us the delay in funding these new centers and when we might expect the VA to request this funding?

Dr. CUSTIS. We have flushed out the GRECC's currently in place, giving them the full complement that was planned for them initially. We simply have not had the resources, we have not had the ability to reprogram resources from our other elements in the budget.

It is too early to talk about the 1984 budget, but we would hope that when the 1984 budget arrives, there is a request for additional resources for increase in numbers of GRECC's.

Dr. HABER. As Dr. Custis said, we have contemplated in accordance with the spirit of Public Law 96-330, on flushing out the extant GRECC's. The Department of Medicine and Surgery did indeed divert some resources including 14 FDEE, and some $517,000 in fiscal year 1982, to do that very thing.

Our thesis was it was important to establish a firm base of the extant GRECC's before we could move forward. Additionally, we requested from Congress and received another 35 FDEE, three full-time personnel for some of our GRECC's that had been funded and

32 positions for fellowship training with the Office of Academic Affairs, so that we requested and got an additional $1.2 million to carry out this mandate.

Mr. MOTTL. On page 14 of the prepared statement, you said to meet the total projected need for nursing home care during the next 5 years, particularly for the aging veteran, the community nursing home program will have to increase at approximately the same rate as the VA nursing home care program.

Based on your statement, I assume this means an additional 3,000 to 4,000 nursing home beds will be required in each program.

The VA has closed roughly 20,000 beds in the past decade.

How can you justify the closing of that many beds when they will be needed for the nursing home care?

Dr. CUSTIS. The closing of the beds in the last 5 years, Mr. Chairman, has been very closely policed and has been due exclusively to loss of beds in the renovation process, correcting fire safety and privacy standards, or violation of standards.

There have been no arbitrary bed closures in the last 5 years.

The need for nursing home beds is based on our projections of demographic data will be much more accurate when we have available the 1980 census.

If we are to continue our fair share of the market needs for veterans requiring nursing home care, it is estimated that by 1990 that same purge of fair share will amount to some 20,000 to 22,000 beds within the system, and if we stick to the same commitment of a 40-40-20 mix, there would be an equal number of community nursing home beds under contract and 20 percent in State homes.

That is quite an impact on the system. At the present time, the census for VA nursing home beds at the end of this fiscal year will be just short of 10,000, and the census of veterans in community nursing homes will be approximately 10,000 as well.

We had been operating under a target of constructing by 1986-87, a total of 13,000 beds which is 7,000 short of the 1990 need.

Dr. HABER. The community nursing home beds we are using should not be considered—the closure of VA beds does not interfere with that was in the community we get people into their own community.

The closure of VA beds does not affect the expansion of nursing home care.

Mr. MOTTL. I will recognize our distinguished colleague and ranking minority member, Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. What are the general critiera being used in evaluating the conversion of existing acute care beds to nursing care beds and when can we expect to receive a list of locations where these conversions are going to take place?

Dr. CUSTIS. We have placed in the field guidance in connection with the grassroots process of medical district-initiated planning. One of their guidelines is that they should look at the option where census is usually low in hospitals. That is in the 65 percentage area, to see whether or not there could not be constructed within the walls of the hospital a nursing home.

We have many hospitals currently that have just that, nursing home units contained within their walls. You will recall that the

Congress recently put a floor under the total beds for the system to include acute care and nursing home care not to fall below 90,000.

We interpreted this to mean that you would agree that within that 90,000 floor, where feasible, beds could be shifted from acute care to nursing home care. We are not yet prepared to tell you, until the input from the MEDIPP process this November, what degree of transfer would be feasible.

This transfer of beds is independent of new nursing home bed construction, in an effort to better utilize those facilities with an unusually low census.

Mr. HAMMERSCHMIDT. When your survey reports are in, in November, it is reasonable to assume you will be able to give us that information early in the next Congress.

Dr. CUSTIS. We would hope, Mr. Hammerschmidt, that somewhere in the months to follow, this November, and after availability of the 1980 census data, that we will be able to put together a very definitive plan for all of our various facilities having to do with the care of the aged. We can be very specific, we hope, sometime after the turn of 1983.

Mr. HAMMERSCHMIDT. You probably have cranked into that evaluation this aberration you are mentioning now on the change in medicaid funding that is creating a problem geographically around the State, skewing the system, so to speak? Will that be included?

Dr. CUSTIS. It is an imponderable, but we are aware of it and are considering it.

Mr. HAMMERSCHMIDT. You mentioned one area specifically in your testimony. Where is that, do you know? "We are beginning to experience this problem on a geographically limited basis?"

Dr. CUSTIS. In the Chicago area.

Mr. HAMMERSCHMIDT. Dr. Custis, I take note of your discussion of the eligibility of nonservice-connected veterans over age 65 to have medical treatment. The law specifically states this treatment is to be given within existing facilities. Why do we keep hearing ominous statements from VA officials that billions of dollars are going to have to be spent on the construction of new nursing homes to take care of the enormous increase in need?

Dr. CUSTIS. Unless we change what has historically been our approach to this subject, we have been attempting to care for approximately 20 percent of the veterans' need for nursing home care.

Of that 20 percent historically we have accommodated it with 40 percent in our own nursing homes, 40 percent in community nursing homes, and 20 percent in State homes.

We know from experience that we have difficulty placing in community nursing homes patients that have need for rather intensive nursing care. The patients in the VA nursing homes are sicker patients than those that we are able to place in community nursing homes.

The cost for new construction of nursing homes is based upon that historical formula, and were that formula to change and we become more dependent on contract care there would be less need for construction of VA nursing home beds.

Does that answer your question?

Mr. Hammerschmidt. I think so. In other words, within existing facilities it is still the policy of the Veterans' Administration, under the formula that you are using now.

Dr. Custis. Yes.

Mr. Hammerschmidt. Thank you, Doctor.

Mr. Mottl. Thank you very much, Mr. Hammerschmidt.

Next we will hear from the gentleman from Pennsylvania, Mr. Edgar.

Mr. Edgar. Thank you, Mr. Chairman.

Dr. Custis, it is good to see you again. We had a chance to see each other amid fireworks in Philadelphia recently, and we had a delightful opportunit[illegible] sit at dinner together and talk about these very issues. It i[illegible]d to see you again.

On page 2 of your statement, you make a point which seems at least on the surface, to be in contradiction with what the Administrator of the Veterans' Administration had said.

On page 2 of your statement, you say that you do not believe that the VA's Department of Medicine and Surgery will be overwhelmed on a given day by the demands for care of veterans 65 years of age or older.

Most of us on this committee are pleased to receive this statement. Yet, Mr. Nimmo, the Administrator, has been quoted in the press saying the VA will be unable to meet these demands and Congress needs to change the eligibility laws.

Can you advise us as to the position of the VA on this matter, at this time?

Dr. Custis. I am not sure that I can definitively tell you at this time what the official agency position is in the matter of how the impact on the aging veteran is going to be met. I can certainly understand Mr. Nimmo's concern that, given the current facilities, that the demands, that the workload of an additional 8,000 to 10,000 veterans who are over the age of 65, given current facilities, we cannot handle it.

The seemingly contradictory statement on page 2 references my belief that we need not expect every veteran over the age of 65 to seek care in the VA system. Those who can afford private care are certainly going to do it.

In the abbreviated statement I tried to give an estimate of what that percentage would be, and based on our current experience, it would be, we think, around 25 percent.

In other words, for every veteran coming to us for care over the age of 65 in the year 1990, there will be at least three veterans who do not come, who will provide their own resources.

Mr. Edgar. You mentioned earlier you were presently providing about 20 percent of the veterans' need for nursing care. Wouldn't you anticipate with the larger number that even providing that 20 percent you are going to have much more pressure on the system?

Dr. Custis. Indeed so. Incidentally, 20 percent has been our target. We have been slipping. Currently, it works out to something like 14 or 15 percent. We have used 20 percent as a target.

Mr. Edgar. You mention on page 1 of your statement about not being absolutely certain of the consequences of these population projects. It seems in the early part of your testimony there is some infusion of words like uncertain and unable to project and unable to make accurate definitive projections, not able to know how many of those veterans would use the system.

Yet, it occurs to me in previous administrations there has been a great deal more alleged, certainly, at least, there have been projections made before that, that were fairly clear estimates of what was going to happen in particular years with veterans' populations.

Is there a reason why the uncertainty level has increased at this point?

Dr. Custis. My own reservations stem from the fact that I obtained my education from Frank Morrone, who is a statistician extraordinaire. May I defer to him in answering your question?

Mr. Edgar. Sure.

Mr. Morrone. I think part of the problem we are facing right now is related to the inability for us to be able to get definitive statistics relating to the veteran population from the 1980 census.

At this time, we have available a 1-percent sample of the veteran population. All the veteran population projections currently being built are being built from 1970 data with migration patterns that have their history in the period 1965 to 1970, so we have some difficulty in trying to get an accurate fix on where people are and how many there are in the country.

Mr. Edgar. Did you make the same projections under the Carter administration using the 1970 data?

Mr. Morrone. There were projections made in the Presidential guidance back in 1977, using 1970 data, that is true. Our target years there, you see, were 1980, 1985. The target years now that we are trying to project to are 1990, and spanning 20 years with that 1970 base gives us a lot of difficulty.

Mr. Edgar. It seems to me from what we know from our VA records and Social Security records, with a little pressure on the Census Department, we should have a fairly clear picture of what is going to happen.

I chair a group called the Northeast-Midwest Congressional Coalition, and we know what happened between 1970 and 1980 in terms of loss of population. We have already moved to reduce by 17, the number of Congressmen in our region of the country, to the south and west.

Florida picks up five Congressmen to match its 5,000 a month veterans that Congressman Mica always talks about.

We see this shift, but the actual number of World War II veterans reaching the age of 65 is increasing. We should have pretty good data on that. The number who need care in the veterans' system, we should have a pretty good handle on that.

The question I was raising earlier is if we could get a handle on those projections and match them with the statements that Dr. Custis made on page 2 about our not going to have the kind of crunch, day and time when we can't meet that need, we could have a better idea of seeing whether or not that is accurate.

Some of us fear that, given the statements of Mr. Nimmo about the projection of 65-years-and-older veterans coming into play, and while the number of veterans may be declining, the percent of aged veterans is increasing so greatly, that we may not have facilities in place throughout the country that can handle that particular need.

I could guess at a few areas where we are going to have a great deal of pressure.

I have additional questions which I will ask in a few moments.

Mr. **Mottl**. Next, we will hear from the gentleman from Alabama, Mr. Smith.

Mr. **Albert Lee Smith**. Thank you, Mr. Chairman.

Dr. Custis, is the position and prestige of gerontology improving any in VA hospitals and the medical community at large?

Dr. **Custis**. I think the answer is definitely yes, both in VA hospitals and in the community at large. This is particularly noticeable in the academic communities now where geriatrics is being added to the content of the medical school curriculum.

Sections on gerontology are being established. As you probably know, Dr. Bob Butler is leaving NIA shortly to be the first chairman of the Department of Gerontology and Geriatrics at Mt. Sinai.

It is slowly but certainly being given increased attention and popularity. I think this is particularly true within the VA. We are very proud of the fact that we, for example, started this graduate training in geriatrics, first in the country. We are now seeing academia following through.

Mr. **Albert Lee Smith**. Is geriatric medicine able to attract a larger and larger share of the research dollar as the general population's age increases? Do you see a trend in that direction?

Dr. **Custis**. Yes, sir. This also is true within the VA research budget. Dr. Haber, I am sure, is very anxious to speak on this subject. It is one of his favorites.

Dr. **Haber**. I think the answer is overwhelmingly yes. The budget of the National Institute of Aging went from a scant $24 million 4 or 5 years ago to what it is today, about $80 million.

We in the VA have seen an increase. Our GRECC's are funded at $6.9 million starting from a base of zero. We are certainly experiencing a growth in the research attention paid to it.

I would like to underscore what Dr. Custis has said about the ability of the best academic minds to address themselves now to geriatrics. We see more and more of that and I think the VA in the GRECC's and the fellowship training program helped influence that change, so I think in some measure we are responsible for the fact that medical academia does now increasingly address itself to geriatrics.

As a matter of fact, I met with a group in Birmingham just a couple of days ago where I found a very heartening interest in geriatrics with a great deal of thought about what they are going to be doing in the near future in this area.

Mr. **Albert Lee Smith**. Thank you. That is where I will be getting older, so I am glad to hear this.

Dr. Custis, what indications have you received that State and community health care facilities and practitioners are willing to share in a larger responsibility to provide health care for veterans? Is there any indication of that?

Dr. **Custis**. I think we see it in our contacts with State authorities, especially in connection with their applications for grants in support of construction of State hospitals and nursing homes and domiciliaries.

We have not as yet contacted community authorities to pursue this idea with reference to the opening statement. We have, however, discussed it with other Federal agencies to see what might be their interests.

We think it has a lot of possibilities and would be really a prototype in the best tradition of State, Federal, and community cooperation in matters of health.

We point, for example, to the precedent of what the Congress assisted us in accomplishing in the AHC program, setting up in cooperation with communities, continuing medical education centers.

We were able in those instances to provide some of the administrative support for those centers. If something similar to that could be done to continue NIDUS, of mobilizing the volunteerism in the community, the Government authorities in the community, the cooperative efforts on the part of Federal activity programs in the community.

We are talking about combined efforts in training hospital-based home care teams, establishing and supervising day care centers, any number of activities that are going to be needed for care of the aging citizens.

Mr. ALBERT LEE SMITH. Thank you, sir.

Mr. MOTTL. Thank you very much, Mr. Smith.

The gentleman from Michigan, Mr. Dunn.

Mr. DUNN. Thank you, Mr. Chairman.

In the first part of your testimony, Doctor, you talk a great deal about statistics and number of veterans now, the number of projected veterans in 1990 that will be over 65, and then you strap on later some percentage of those that will end up on VA hospitals. I have a fear there is an overreliance on those statistics.

You do talk in your testimony about community involvement programs. I am eminently aware there can be vast differences between a community 50 miles up the road from another community in types of services offered, whether it be VA hospitals or private hospitals contracting out nursing homes or even university hospitals and I am just wondering, in the survey you are doing, is that going to be the bigger determining factor in whether we locate and/or build a new VA hospital in any given area than some statistics—about 6 months ago, we had some testimony on this committee and the main argument revolved around the city we were proposing to build a hospital in, whether there was actual need for it, and I guess what I am trying to say to you is that, compared to using statistics versus this Outreach community program, I would urge you to use the actual needs of whatever given community as the more important criteria in determining.

Do you have any problem with that?

Dr. CUSTIS. None at all. I think it is important that we consider all aspects of optional methods of care. It is interesting that you have warned us about overreliance on statistics. Mr. Edgar warned us about underreliance on statistics. Maybe somewhere in between we will strike the median.

Mr. DUNN. Mr. Edgar has been in Washington longer than I have, and utilizes statistics more than I do.

Mr. EDGAR. Would the gentleman yield?

Mr. DUNN. I would be glad to yield.

Mr. EDGAR. I think both of us are just looking for factual data with which to do adequate planning. Statistics can be manipulated and used but they can also be clear, concise, they needn't be burdensome and I think, as a medical director and a planner, it is really important for you to have those factual pieces of information to make a decision.

I am going to ask some questions in a few minutes about whether or not the requests of the administration reflect a knowledge of what is happening to us or whether or not we are fuzzing up statistics so we don't have to make requests.

These are times of tight budgets, times when it is difficult to make requests for certain kinds of care to be provided if the dollars are not available, but somebody has to make that decision. The choices are difficult.

I think the gentleman from Michigan is also interested. He wants to know what are the facts. The gentleman from Pennsylvania feels the same.

Mr. MOTTL. Mr. Dunn, I hope we are not going to use these statistics as a drunk would use a lamppost; that is, for support, not for enlightenment.

Mr. DUNN. I will leave it right there. Thank you, Mr. Chairman.

Mr. MOTTL. Next we will hear from the gentlewoman from Massachusetts, Mrs. Heckler, who has been most instrumental in this entire program, and I am sure she will have some penetrating questions for the doctor.

Mrs. HECKLER. Mr. Chairman, we consider Dr. Haber the godfather of the geriatric program. Anyone who knows the history of the concerns of the aging veteran realizes how long and hard he has worked on this subject and also on subjects that relate to agent orange.

This is a gentleman who has had enormous experience.

With your permission, I would like to address my questions to Dr. Haber. Dr. Haber, how would you rate the progress of the geriatric program at the VA?

Dr. HABER. I think our progress has been better than satisfactory. That does not deny the fact that much remains to be done. I know you are exquisitely aware of that as are other members of this committee.

We feel that the whole progress of geriatric research, education and clinical care has been enormously improved and abetted by the passage of Public Law 96-330, of which you are the sponsor. I think your personal interest has been a source of inspiration and a touchstone for all of us who are interested in bettering the care of the geriatrics.

I would say that applies as well to all the members of this committee. I think the committee has been one of the most constant and profound sources of inspiration and guidance for us in the care of the geriatric patient.

We have engaged in a great deal of research, we have trained a lot of people. First and foremost I think has been the fact that geriatrics has become respectable. Dr. Custis addressed earlier a question from one of the members of the committee as to the progress in geriatrics and he pointed to that fact.

I think the growth of the GRECC's, along with the printing program, stimulated medical academia in the best elements of medical care, including nursing, psychology, social work service, and many other disciplines and has improved our lot enormously.

I think the geriatric patient in the Veterans' Administration has benefited considerably from this.

Two main thrusts, I think, that have developed are, one, the development of the geriatric evaluation units attributable in large measure to the GRECC and the current interest in Alzheimer's disease.

Both of those have held great promise for the improvement of geriatric patients.

Mrs. **Heckler**. Do you see a difference in the attitude of the medical schools? Earlier, when we had hearings there were very few medical colleges which actually had geriatric courses.

Has this changed, and do you think the geriatric program at the VA as a result of that legislation, has that made a difference?

Dr. **Haber**. Indeed it has, and I think the tide is running in favor of inclusion of geriatric material. In the curriculum of medicine we are fortunate to have John Mather, who has devoted a considerable amount of time to the study of increase in geriatric material in the curricula and I am sure he intends to see that this procedure continues.

Mrs. **Heckler**. How long have you worked in the field of geriatrics?

Dr. **Haber**. About 25 years.

Mrs. **Heckler**. I know your relationship to it has been essential. I would hope that your guidance will continue.

Dr. Custis, you have been so involved with all of the medical programs, and this is only one facet of them, but how would you rate the progress in the geriatric program?

Dr. **Custis**. I would agree with Dr. Haber—something more than satisfactory. We still have a long way to go. Incidentally, all of us consider you the godmother of the GRECC's.

Mrs. **Heckler**. Thank you.

I am pleased with the progress in my own State. I am very impressed with the big thrust. The geriatric program is the most sought of in terms of individuals seeking assistance as they age. They feel very fortunate to be included in the GRECC program, it is our hope.

I am disappointed with the lack of support for the development and expansion of this program in the VA. I don't mean to imply this is your fault, Dr. Custis. I think there are so many factors and so many drains on the budget, but I think it is a major mistake to have the VA not move aggressively in this field.

Mr. **Mottl**. Thank you very much, Mrs. Heckler. We all concur on your wonderful contribution to this program and you are to be complimented.

We will recognize Mr. Edgar for one or two concluding questions. We know you have to leave to get to another meeting, Dr. Custis, and we have another panel waiting here patiently.

We will now recognize Mr. Edgar to conclude the questioning of the first panel.

Mr. **Edgar**. Dr. Custis, on page 9 of your statement, you make the comment that in order to make this kind of geriatric system work, that you are convinced that we must be granted more flexibility in management of these centers.

What specifically do you mean, and do you have legislative proposals to give you that flexibility?

Dr. **Custis**. Specifically the definition in law for a GRECC is very detailed, very specific. I think we have learned from experience there currently are not, and probably never will be, two GRECC's that are exactly alike, nor should there be.

We see as we expand GRECC's, the need to emphasize some elements of a GRECC's capability over another, depending on the makeup of the GRECC and the locale where it is placed.

That is the sort of flexibility we would like to see.

Mr. **Edgar**. Do you need the law changed to give you that flexibility? Can you use that flexibility under your own administrative power?

Dr. **Custis**. It is our general counsel's opinion it would be well to modify the definition of a GRECC in law.

Mr. **Edgar**. Do you have legislative language you would like to submit to us for consideration?

Dr. **Custis**. We will have shortly.

The other thing is that GRECC's are, and will always be, just a part of the total geriatric programing in the system but they can be, with modification of their role, the NIDUS have a lot of new programing not previously assigned to them.

Mr. **Edgar**. I think all of us will look forward to receiving that legislation.

On page 1 of your statement, you use the word "prudent" in relationship to being prudent with statistics and prudent in the direction in which we should go.

Someone has said prudence is a virtue but another explanation says he who hesitates is lost. It seems to me we have to be careful that in our prudence we are not in a position where we do not have in place, with the influx of aging veterans, the kinds of quality care facilities that Mrs. Heckler and others have been instrumental in putting in place in certain areas in the country. I think the expansion of the GRECC program is critical, in that while it will cost a little bit of money, I think it is important to make the necessary resource adjustments to care for those aging veterans who have the need, which both you and others on your staff have indicated have been successful.

And if they have been successful in limited use, it seems to me they would be successful in an expanded and more enthusiastic use of them.

It would be helpful for us to know when, if ever, you, as Administrator, have asked OMB for additional resources, asked the President for additional commitments for this kind of care for geriatric medicine. Have there been those requests that have been denied or at this point have those requests not been made?

Dr. **Custis**. Not only requests for GRECC's, but other proposals have been submitted with every budget cycle and then in the process of arguing and establishing relative priorities for programs, initial requests have itself been eliminated or modified greatly.

Not only GRECC's, but other programs as well.

Mr. EDGAR. Mr. Chairman, with your permission, just two quick additional areas, and I will be very brief.

I serve on another committee, Public Works and Transportation, which has a subcommittee dealing with GSA. It has come to my attention that a facility at 417 South Hill Street in Los Angeles, Calif., which is a veterans' outpatient clinic, has a present lease of $1.2 million.

The renewal of that lease by GSA will now cost between $4 and $5 million annually and they are about to move to the renewal of that lease because of the restrictions on NIDUS construction.

We will spend approximately $10 million by 1985, in 2 years, 1983, 1984, to 1985, in leasing an outpatient clinic in the Los Angeles area.

It doesn't make a lot of sense to me on paper and it would be helpful if your staff could get back to me and to this committee as to why we can't move toward construction of that facility, or look for a cheaper lease facility in that area.

GSA indicates it is willing to construct the facility, that there is land available. Rent over a 10-year period of time for this lease would be $50 million. That seems like a sizable piece of change to me for the renting of a facility. If you invested that $50 million over that same 10-year period you could have a long-term facility that could either be sold in the future or disposed of in another way.

I hope that your staff can take a look at that.

Finally, throughout your statement, there are references to more New Federalism, more community involvement, or a feeling that the veterans' health care system has to move out into the neighborhood.

It would be helpful if we could have some clarity on what is meant by that because the traditional debate within Congress and within other institutions as to how we care for veterans' needs, and these alternative facilities that you are talking about—we have had some experience, for example, in the readjustment counseling centers, the storefront centers.

Is that what you are talking about? Are we talking about an adopt-a-veteran policy—adopt a sick veteran in your home, or are we talking about a better use of vouchering for veterans in nursing homes rather than building facilities of our own?

It may be if there is a blip in the statistical flow—that is if a large influx of new veterans are entering the geriatric area, there may be some instant or temporary facilities that ought to be established that could be later phased out after the influx, so we don't know what many school systems have done around the country, which is build school facilities to care for the children and then have the population decline and not have a need for those facilities.

If you could tell us what the discussions are about, New Federalism and new responsibility at the local level to care for the aging veteran, it would be very helpful.

Thank you, Mr. Chairman.

Mr. MOTTL. Thank you very much, Mr. Edgar.

Dr. Custis, before you leave—and we want to compliment you and Dr. Haber and the rest of your staff for the fine job you did here this morning, but what has happened to the proposed outpatient clinic at Gary, Ind.?

If you could kindly inform Mr. Casteel some time on the progress of this outpatient clinic we proposed for Gary, I would appreciate it.

Dr. CUSTIS. May we provide that for the record? To the best of my memory, final decision was made that the VA did not concur.

Let me recheck it.

Mr. MOTTL. I hope that is erroneous, that conclusion.

I think Mr. Edgar had a hearing there.

[Subsequently, the Veterans' Administration furnished the following information:]

The Administrator's letter of March 17, 1982, to Congressmen Edgar and Hillis, advised that an interim solution to the establishment of an outpatient clinic in this area was not feasible and that only a comprehensive clinic requiring new funding would be advisable.

We believe it would be prudent to defer any such solution until our MEDIPP plans are received and analyzed on a nationwide basis. In this process, we can determine where health services should be optimally delivered based on such important variables as the size, age distribution, and proportion of service-connected versus nonservice-connected veteran population.

Mr. EDGAR. I think the bottom line is that the information that we had back was no decision was going to be made at this time, and no facility was going to be—no temporary facility was going to be placed in the Gary area. That is the alter information I have on the issue. Adam Benjamin is very concerned about it.

Mr. MOTTL. Rightfully so, because it was shown they did not have adequate facilities.

Mr. EDGAR. The transportation problem is there.

Mr. MOTTL. Thank you very much, Dr. Custis.

Our next panel of witnesses includes Gabriel Brinsky, national service and legislative director, AMVETS; Paul Egan, deputy director, National Legislative Commission; John Sommer, Jr., deputy director, National Veterans Affairs and Rehabilitation Commission, the American Legion; Donald H. Schwab, director, National legislative Service, Veterans of Foreign Wars; and Gordon Mansfield, associate legislative director, Paralyzed Veterans of America. If you would come forward at this time.

Your entire statements will be submitted in the record in their entirety, and you may proceed as you see fit.

The Chair would like to apologize. At the last hearing I understand you were cut off short. We want to apologize because you people should never be cut off short.

You have contributed so much to all of our veterans and our policy decisions here, and we look forward to your testimony here this morning, and your contribution to this hearing.

First we will hear from Mr. Brinsky.

It is a pleasure having you and the other gentlemen here this morning.

STATEMENTS OF GABRIEL BRINSKY, NATIONAL SERVICE AND LEGISLATIVE DIRECTOR, AMVETS; PAUL EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION; JOHN SOMMER, JR., DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; DONALD H. SCHWAB, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS; AND GORDON MANSFIELD, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. **Brinsky**. Thank you, Mr. Chairman.

AMVETS appreciates the courtesy and privilege extended by this committee to express its views on the health care needs of aging veterans and the geriatric research education and clinical centers.

Because of the time restraints, we will briefly highlight our anxieties concerning this most important issue. We request that our complete statement be incorporated into the record.

Mr. **Mottl**. Without objection, that will be done.[1]

Mr. **Brinsky**. Allow me to begin by stating that less than 10 years from now, two out of every three males in the United States over the age of 65 will be a veteran. It is projected that in less than 20 years there will be more than 8 million veterans when almost one-third of the veteran population will be over 65 years of age.

This is worth pondering in terms of need for health care facilities and resources as it relates to the aging population. In this framework of patient potential, we must also accept the fact that older patients require frequent hospital admissions with its longer hospital stays and, of course, more medical attention by physicians.

It is common knowledge that the older veteran is more likely to develop more complicated illnesses. The course of diseases in the elderly greatly differ from the manifestations and the course of diseases in young adults.

Accordingly, in terms of treatment of the older persons, a modification is required as well as in the administration of drugs used in such treatment in order to relate to their responses.

By reason of advances in medicine in recent years, it is possible for patients to withstand diseases such as diabetes, arteriosclerosis, and cardiovascular diseases without prevention or cure of these illnesses.

Currently, there are eight VA geriatric research, education, and clinical center programs referred to as GRECC. The program was initially established in 1975. Public Law 96-330 authorized the development of seven additional geriatric centers.

One of these was planned for Camden, N.J., which was scrapped. We are concerned that the pressing need in this most important area of health care is being treated with cavalier indifference.

Recently, of the 2,000 people working for the Veterans' Administration, there was in the neighborhood of 150 people who were employed in the geriatric program. It is evident that the program is not receiving the attention it deserves just as it is patently clear that not enough research is being done on the hospice program for the care of the terminally ill patients.

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[1] See p. 48.

It would appear that these urgent priorities have been relegated to the bottom of the list for the purpose of allocation of resources.

This is not to suggest that the indifference to this most pressing need is due to the Department of Medicine and Surgery of the Veterans' Administration. Dr. Donald Custis, the Chief Medical Director of the Veterans' Administration, in recent testimony before the Senate Veterans' Affairs Committee, acknowledged that while Public Law 96-330 authorized expansion of the GRECC program up to 15 GRECC's, the resources were not forthcoming to make this possible.

We realize that the demands upon the Veterans' Administration health care system are many. And we appreciate what Dr. Custis is advocating that we do not overemphasize the need for health care at the expense of the other services provided which will make the system inoperable.

But we continue to be of the opinion that time is of the essence. We can no longer delay in setting up the mechanism that will be required to take care of our aging veterans. And unless we begin now, we will not be ready.

For much needs to be done, not only in the clinical medicine area but in the realm of innovation and imagination if we are to most effectively treat and take care of our aging veterans.

We are awaiting with great anticipation the report and findings by the Geriatrics and Gerontology Advisory Committee which is conducting its studies and will report to the Congress concerning its findings and recommendations.

In our statement, which we have requested be accepted as a part of the record, we have set forth our views and suggestions as to how we can enhance the betterment, in terms of health and care, for our aging veterans.

This concludes my statement. Thank you.

Mr. **Mottl**. Thank you very much for your excellent statement.

We will next hear from Mr. Gordon Mansfield, associate legislative director, Paralyzed Veterans of America.

STATEMENT OF GORDON MANSFIELD

Mr. **Mansfield**. Thank you, Mr. Chairman. I would ask that my complete statement be included in the record, and I would like to comment on particular points.

Mr. **Mottl**. Without objection, your statement will be included in the record.[1]

Mr. **Mansfield**. First of all, with regard to all aging veterans , we believe the GRECC program is a unique program, and, as has been testified earlier this morning, this is more than a satisfactory program.

It is a prototype for the geriatric and gerontology medical community of the whole United States, not just the VA population. We believe the VA must make a commitment to funding further centers in order to meet the needs of the aging population.

There is obvious growth and obvious need for further facilities. I was happy to hear the discussion between Mr. Edgar and Dr.

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[1] See p. 57.

Custis concerning the possibility of the General Counsel providing suggestions for language for further amendment or other change of Public Law 96-330.

I believe this committee has to take the lead in obtaining more than the eight existing centers. I think it is obvious from the last few budget proposals that the priority does not exist for GRECC's at some level. PVA believes it is in OMB that funds are restricted.

I am sure the VA is commited to this program. But, I believe they need more support, especially, from this committee and the Congress.

I would also like to point out PVA believes there is a need for nontraditional treatment modalities which were discussed earlier by Dr. Custis.

However, we would like to point out that PVA does now believe, as it always has, the preeminent principle is that the Federal Government is responsible for the care and treatment of the veteran population under the Constitution.

One other point I would like to make is concerning the statistics. I believe most of what we have heard here this morning takes us up to around 1990. However, if the figures are projected for the next decade or even into 2010, we will see the figures are constantly increasing and the need is not just through 1990, but through 2000 and 2010 and further on.

So, when you consider, and the VA considers, what the requirements are, we are not talking about a 10-year period or 20-year period but actually a minimum of 30 and probably 40 years where this large bulge in population will require treatment.

With regard specifically to the aging SCI veteran, I would refer you to our prepared testimony and point out the need for expanded bed requirements within the VA. PVA was fortunate to testify just recently before this subcommittee on VA requirements in Florida.

We pointed out the problems with Tampa, where the SCI unit is running at 100 percent capacity.

There are other areas of the country. Our testimony on page 20 shows the results, the preliminary results of a study that PVA and the VA SCI service has been working on with regard to registry of SCI veterans.

Interesting points from this are, the relationship of the SCI respondents in relation to the total general veterans' population.

The top 10 States for SCI respondents were California, Florida, Texas, New York, Pennsylvania, Ohio, Michigan, Illinois, Massachusetts, and Wisconsin. This differs a little bit from the general veterans' population.

There are other facts available in the survey which we hope to be able to present in the near future which indicate that of the respondents, 51 percent are World War II veterans and 19 percent are Korean war veterans.

These facts obviously have implications for the needs of the aging veteran. This leads me into my next point, which is discussed in the testimony which is the proper mix of beds within the SCI unit.

In other words, the need for acute, long term or rehabilitative type beds and then the extended care beds. We pointed out that the proposed 1980 to 1987 SCI bed plan which set a total of 1,565 beds did propose a change in the proportion, the rate of extended care beds being raised from approximately 25 to 31 percent.

PVA will continue to work with the VA SCI service in dealing with this data and the implications it has, and we hope this will be taken into consideration by the VA in their planning.

In my prepared testimony, I also mention some other items which I believe the VA could investigate for not only SCI veterans but all veterans. One is the satellite clinic outside the present 50-mile radius.

This, again, was a point raised in reference to the Florida testimony. I expressed some of my ideas about the possibility of putting these satellite clinics out in a further radius, developing VA teams of medical specialties with perhaps the clinic having a day for geriatric specialty teams or a day where the clinic would have SCI, a day with cardiac specialty teams.

We believe this would be a cost-saving measure in the long run, because you would reduce some of the extensive travel requirements for the veterans and you would have the VA concentrated in one location.

Another point we would like to make is there is a possibility here under the VA, DOD sharing agreement that there might be a possibility of using DOD facilities and equipment and maintenance personnel and support.

Other ideas which PVA has outlined and believes are viable options for the VA to consider are independent living centers, the hospital-based lone care program and programs such as the fee-based home health care.

PVA believes all of these programs are cost-effective, cost-saving measures the VA should look at. What we are talking about, particularly with regard to the catastrophically disabled veteran, is removing him from the hospital where we realize the costs are going to be constant and high, and putting him in the community or home location with the needed level of care provided.

PVA believes consideration of these ideas could be cost effective.

Mr. Chairman, that concludes my presentation. Thank you very much.

Mr. MOTTL. Thank you very much, Mr. Mansfield.

Next, we will hear from Mr. John Sommer, Jr., deputy director, National Veterans Affairs and Rehabilitation Commission for the American Legion. Mr. Sommer, welcome.

STATEMENT OF JOHN SOMMER, JR.

Mr. SOMMER. Thank you, Mr. Chairman, and members of the subcommittee.

The American Legion appreciates this opportunity to present the views to the subcommittee on the subject of Veterans' Administration programs for aging veterans.

Mr. Chairman, we commend you and the members of the subcommittee for taking up this subject. The problems that will confront the Veterans' Administration between now and the year 2000 in dealing with the aging veteran population are massive.

They will require not only conceptual and strategic planning by VA, but most definitely will require legislative support by the Congress. Never in the history of veterans' affairs in our Nation has the Government had to manage a problem of this nature and this scope.

The existence of the problem itself, of course, is the result of the fact that the United States has engaged in four wars in the 20th century, and in doing so has created a veteran population in excess of 30 million, most of whom served during World War II, between 1940 and 1946.

The American Legion does not have the capability to develop the conceptual planning necessary for this problem. We have been, and we will continue working with both Congress and VA to evaluate, appraise, and lend our best judgment to the work of the professionals who are involved in this effort. We are in the role of consumer advocate, and we are attuned to and responsive to the needs and desires of the veteran population.

It would be our suggestion, beyond this, this oversight examination, the committees of Congress should undertake no definitive planning for the future of VA programs for aging veterans until the committees are in receipt of a report from the Geriatrics and Gerontology Advisory Committee established under the legislative authority of Public Law 96–330.

Among the commendable features of that act which had the support of the American Legion was the establishment of the GGAC. The Geriatrics and Gerontology Advisory Committee will submit its first report to the Administrator in the near future and it will include specific recommendations for consideration by Congress in planning for care for the aging veterans.

It is clear that the impact of the aging veteran population is already going to be felt by VA as witness among other things the 95-percent average daily patient census of the nursing home care units, and the fact that practially all of them have waiting lists.

Acute care beds are seeing more of the catastrophic illnesses associated with advancing age such as heart disease, stroke and malignancies. We believe VA is dealing with these as well as it can with its present resources, and recognizing the maximum level of anticipated impact yet lies ahead.

It cannot be said the VA Department of Medicine and Surgery has not done planning and instituted initiatives with reference to aging veterans as witness the planned increase in nursing home care beds and the eight current geriatric research, education and clinical units.

It is to be noted that a total of 15 of these GRECC's are authorized by Public Law 96–330, although funding of the additional 7 has not been provided.

It is our belief also that more funding and encouragement, from the central office and from Congress could and should be directed to the research efforts of the GRECC's.

Basic research in the field of geriatric medicine is much needed by the general field of medicine; and VA as it has in some other fields, such as in hypertension, could be a leader in this area, in part because of its increasing aged clientele.

The American Legion is also very supportive of such programs as hospital-based home care and the foster home program.

If the forward movement of the practice of medicine in the VA Department of Medicine and Surgery is toward providing care for the veteran as much as possible in a deinstitutionalized setting, then this is going to create problems in both VA and Congress.

The question is going to be—can community based programs be made cost-effective—and can the Nation afford them. We of the Legion support the theory of maintaining the veteran patient in the community as much as and for as long as possible.

We recognize too, that there are limits to what the government can afford, even in the application of advanced principles in the practice of modern medicine.

The American Legion wants the present medical care program to be maintained, first for the service disabled, and then for those veterans who need and apply for care from the VA system.

Our position is consonant with the commitment first made to the Nation's war veterans by Congress when it passed the World War Veterans Act of 1924, and Congress has taken no action to rescind that commitment.

In summary, let me say that the VA is doing many things in the area of development of programs for the care of aging veterans. Congress has been very supportive, for which The American Legion is certainly grateful. This Nation must not turn its back on the young men and women who fight its wars, when they become old. The American Legion has said, and says again, that the Nation that forgets its war veterans is in danger of losing its soul.

We do not believe that is going to happen in our country.

Thank you, Mr. Chairman.

Mr. MOTTL. Thank you very much, Mr. Sommer, for your outstanding statement.

Next, we will hear from Donald H. Schwab, director, National Legislative Service, Veterans of Foreign Wars.

It is a pleasure to have you here, Mr. Schwab, and we look forward to hearing your testimony.

STATEMENT OF DONALD H. SCHWAB

Mr. SCHWAB. Thank you, Mr. Chairman.

Thank you for the privilege of appearing before this distinguished subcommittee to present the views of the Veterans of Foreign Wars of the United States. My name is Donald H. Schwab, and it is my privilege to serve the 1.9 million members of the Veterans of Foreign Wars as their national legislative director.

I will summarize my testimony and try not to be redundant.

Mr. Chairman, the Veterans' Administration extended care program is tailored to the needs of older veterans and embraces long-term care in VA and community nursing homes, domiciliary care, hospital-based home care, residential care, all care in State home facilities, and the geriatric research, education and clinical care program.

The necessity for these programs is quite evident, due to the increasing number of older veterans. Mr. Chairman, Public Law 97-72 mandates the Veterans' Administration to maintain not less than 90,000 hospital and nursing home care beds combined.

Whether the VA operated 110,000 hospital beds or 80,000 as they are now, they have run almost constantly a 20-percent ratio of empty beds. I think the figure currently, the daily census, is 17,000 empty beds.

In view of the fact it is nearly impossible to gain admittance to a VA nursing home for a veteran, we suggest, as we have numerous times in the past, that the VA redesignate some of these hospital beds as nursing care beds.

Mr. Chairman, Public Law 93-82, which was approved in August 1973, provides for home health services to chronically ill veterans. This is a good and cost-effective program which unfortunately has not been expanded due to the absence of adequate funding.

Of the 26 VA medical centers presently participating in the home-based health care program, the last activation of such a unit was in January 1974.

The GRECC program, the expansion of which was authorized by Public Law 96-330, was supposed to have been funded in the amount of $10 million in the fiscal year 1981 and $25 million in each of the following 3 years.

Notwithstanding the obvious need for this program, the fact that both the House and Senate overruled the President's veto of the enacting legislation, no money has been forthcoming for expansion of this great program and I think that is a real shame.

Public Law 96-22 established a 5-year pilot program of preventive health care services for veterans with 50 percent or more service-connected disability ratings and this program received maximum funding of $10 million in 1980, $12 million in 1981, $13 million in 1982, $14 million in 1983, and $15 million in 1984.

No funding has been specifically appropriated for this program and VA information sources indicate only a dribble of money has provided for this program.

Mr. Chairman, one of the provisions of Public Law 96-466 provides for a 4-year pilot program of independent living and assistance for severely disabled veterans for which vocational rehabilitation is not reasonably feasible.

It is my understanding that 20 months after this law has been in effect, there are only 17 veterans participating in this program and last month the VA issued a news release captioned "VA Seeks Veterans for New Independent Living Services Program."

Mr. Chairman, there are those in the administration and even Members of Congress who have uttered public statements published in national magazines and syndicated columns to the effect that Congress has got to do something about veterans, or they are going to break the bank.

This is not so. I think your House Veterans' Affairs Committee Print 74 to the Budget Committee dated March 15, 1982, graphically outlines that veterans are not the ones who are going to break the bank.

It is the opinion of the VFW there are enough laws presently on the books to take care of our aging veterans in the foreseeable future and other veterans. If they would fund the GRECC program, the independent living program, the construction program, the State grant programs, that is all that is needed now.

The VA cannot continue to sustain cuts in their budget—and by cuts, I mean a lesser percentage of the Federal budget year after year—and provide the veteran a service envisaged by Congress.

The budget for fiscal year 1983 is 3.09 percent of the Federal budget in outlays. This is the lowest it has been in 10 years.

This has got to be reversed. The VA has got to get a larger portion of the Federal budget or I am afraid we are going to be in deep and irreversible trouble in our health care system.

That concludes my summary, and I will be happy to respond to any questions you may have.

Mr. MOTTL. Thank you very much for your outstanding statement, Mr. Schwab.

[The prepared statement of Mr. Schwab appears on p. 94.]

Mr. MOTTL. Mr. Schwab, I would agree with your comment on the budget. I think it is important that we emphasize for the record—this is the Chair's belief—that the veterans' health care program is just as essential to our national defense as any new Department of Defense weapons systems, and I think we have to keep emphasizing that.

Hopefully, it will stick in with the administration and also with the Congress.

Would any of you like to comment on the constant decline of the various domiciliary beds? I believe it has declined to less than 9,000 beds at this time. Do any of you have a comment with regard to that?

Mr. MANSFIELD. I will respond, Mr. Chairman.

This is another point that was brought up with Dr. Custis here this morning. It was pointed out that last year this Congress was required to put a floor which the VA couldn't go below in reducing the number of beds.

It was pointed out that the reduction of beds in the last 5 years has been done prudently, perhaps: However, from the viewpoint of one veterans' service group, we have seen a reduction in the total number of beds. In all beds. Not just in one area. We point out in the prepared statement that one way perhaps to solve the problem is, instead of closing wards in hospitals that are viable hospitals that continue to operate, that don't have the safety problems, or privacy problems, or the aging-facility problems, to use some of those wards in a different type of treatment, including care for the aged.

We believe this would be one of the solutions to the problem.

When you talk about the reduction in domiciliary beds, you can't just point that out although it is a problem for the aging system, but it is a problem throughout the VA system.

We have also seen a problem existing right now with regard to further construction and what the Administrator has done about that problem.

Mr. SCHWAB. According to the VA, the average stay in a domiciliary bed is 4 years. I think one of the saddest things that can happen to a person is to become institutionalized.

I think the program the VA has in preparing veterans to return to community living is mightily commendable and should be expanded.

Mr. Mottl. So the floor the Congress put in recently of 90,000 beds, you believe that should be expanded, the number of beds.

Mr. Schwab. The 90,000 beds, sir, is hospital and nursing care beds combined, not domiciliary beds.

Mr. Mottl. Now, talking about the 90,000 floor we established by statute recently in the Congress, do you think that is sufficient, it should be more or less? Do any of you have a comment with regard to that?

Mr. Schwab. We have suffered a bed reduction over the years, and Dr. Custis says, it is primarily because of fire safety and privacy standards.

We believe, Mr. Chairman, that veterans who should be hospitalized have been denied care over the years due to the absence of appropriate funding and personnel.

How many beds you have and how many are occupied are controlled by how many people you admit for hospitalization. We have testified before and submitted documentation from veterans who have been denied care at VA facilities and have been forced to go to community facilities as welfare patients.

The 90,000 beds is a minimum, according to Public Law 97-72, and the VA is to keep up to 125,000 beds as a contingency backup for the Department of Defense.

I understand the VA is required, and I haven't seen it in the law, but they are required to keep 10 percent empty beds. But they have been running, as I said before, 20 percent over the years.

Mr. Mansfield. I think not only are we discussing 90,000 beds here for the very system, but we are also supporting all the support staff that is required. Every time you open up another bed, we realize you are going to spend more money than just for the bed and sheets.

You have to have support personnel, maintenance personnel, nursing care personnel and provide a doctor. I think the VA is caught in a position which was pointed out by Dr. Custis.

They go down and ask for more funds and are told they can't have them. The problem then becomes how do you take the number of beds you are allowed to maintain and create the correct mix? I have pointed out in my testimony that I know there are not enough SCI beds out there, especially in certain areas.

Mr. Sommer. I agree the Department of Medicine and Surgery must not lose any additional beds, if the VA is to care for the Nation's veterans and also serve as the primary medical resource backup to the military.

If we lose additional beds, there will be a big problem and most likely legislation will have to be introduced in the future to increase the total number of beds.

Mr. Brinsky. Mr. Chairman, I would like to comment on this, also.

The VA, in the past, under bed reduction, has pointed to the need to do so for reasons of safety standards. They have also said because of improved medical skills, they have been able to lessen the number of days required.

They have used these statements as a basis for the reduction in beds. This may be true, that these were bases, but the important thing, as Mr. Schwab has pointed out, the VA could have handled many, many more veterans than it is now handling if they gave them eligibility or if it admitted them for in-patient care.

There are a number of veterans who are being turned down daily by our VA hospitals supposedly because they do not have eligibility and there are no available beds. So there is no floor, really, that is applicable in this situation, if you look at it in terms of floors.

I think if it were unlimited the VA could take care of many, many more people than it is taking care of today.

Mr. **Mottl.** Thank you very much.

Mr. Casteel?

Mr. **Casteel.** Mr. Brinsky, we constantly see the occupancy rates of VA hospitals. Most VA hospitals right now are running 74 to 80 percent occupied. What you are saying is that with these low occupancy rates they are still turning down veterans.

What we see is that, if they reduce a given hospital by another 60 beds, 40 beds or whatever, that statistically the occupancy rate of a given hospital stays constant at about 75 percent. In other words, if you reduce 40 beds out of a 500-bed hospital, and leave a 460-bed hospital, it still would be only 75 percent occupied.

I think it is a funding problem in that the VA is not being permitted to ask the Congress for adequate resources.

Generally, when the VA comes to the Congress with a request for funds, it usually is granted. At least we knock ourselves out trying to support the request.

It is awfully hard to support funds that they do not request, or say that they really do not need. Those are the kinds of answers we get from the VA. Would you care to comment on that?

Mr. **Brinsky.** I can see what you are saying and where you are coming from. The problem is not so much with the VA or the Congress. The Congress has been most generous, I think. The problem is with the executive branch of the Government.

They have problems with OMB and they have to pass a budget through them. You can't expect them to come here and oppose whatever action they have been directed to take.

I think the problem is there rather than with the VA itself.

Mr. **Mottl.** The Chair would like to thank all of you for the excellent job you have done here this morning, and 2 weeks from today, on the 28th of July, we are going to have the spinal cord injury hearing and we are going to reverse the procedure.

We are going to have the veterans' groups on first, and then have the VA. We want to invite you to also testify 2 weeks from this morning at 9 a.m. in this same room. We look forward to your testimony on that day.

Thank you for the excellent job you have done here.

Mr. **Mansfield.** Thank you very much, Mr. Chairman. I am sure the Paralyzed Veterans of America will be here in 2 weeks.

[Whereupon, at 10:40 a.m., the subcommittee was adjourned.]

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APPENDIX

STATEMENT OF
DR. DONALD L. CUSTIS
CHIEF MEDICAL DIRECTOR
VA DEPARTMENT OF MEDICINE & SURGERY
BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

July 14, 1982

Mr. Chairman and members of the Committee, the opportunity to discuss Veterans Administration programs for delivering care to older veterans and to consider some of our thoughts about a predictable future in which the number of older veterans is bound to increase is both welcome and necessary.

The context for this discussion consists in some statistics of which I am sure all of us are aware, and in drawing some conclusions about them to the extent that it is possible to do so on the basis of our current knowledge--which is limited.

In other words, I am not absolutely certain of the consequences of these population projections, I do not believe that anyone else is or can be certain of them, and I can only propose that we be prudent in looking at and considering them.

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We are told that the number of veterans over age 65 is 3.3 million in 1981, is projected to increase to 7.7 million in 1990, and to 9 million in the year 2000. Expressed as a percentage of the total veteran population, the comparable figures for these same years are 11%, 27%, and 34% respectively.

Let me say, in respect to those numbers, that I am not here to certify some of the more frightening forecasts that have been made. There is an increasing tendency to understand that not all the aged are alone, friendless, ill, poverty-stricken, helpless and without resources. That applies to the population in general and it applies to aging veterans. Therefore, I do not believe that the VA Department of Medicine and Surgery is going to be overwhelmed on a given day demands to provide total care for all 7.7 million veterans over 65 in 1990, or all 9 million in the year 2000.

If we should not anticipate the "worst," what should we anticipate? I believe that the best answer we can give now is a prudent projection for this not-certainly-known future.

That approach stems from the best currently available data we have about who uses our system. In 1981, some 798,000 of the 3.3 million veterans over age 65 came to the VA for one form of care or another. That represents nearly 25 percent of that group. Thus, it seems to me that the lowest common denominator of prudence requires that we should plan for about 1.8 million of the 7.7 million in 1990 and 2.2 million of the 9 million in the year 2000. I say that is the

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lowest common denominator because no one, surely, has any reason to suppose that there will somehow be a lesser proportion of such populations seeking care at that time.

It is evident that even if we leave the matter there, our system would be experiencing overall demands for care that would exceed our current ideas about adequate resources. But I would not myself leave it there.

I think that the proportion of probable users or would-be users of VA health care system within the total pool of over-65 year veterans is likely to be somewhat greater than that. I believe that this is so because predicted increases in Medicare deductibles and co-insurance and reductions in Medicaid funding will make VA more economically attractive or even necessary to the future population pool than it was to the 1981 population pool. We are beginning to experience this problem, on a geographically limited basis, where cuts in Medicaid funding have already produced locally observable increases in demand for care.

I am unable to say exactly how many more of these users there will be because no one can tell me exactly how and when all the Medicare and Medicaid changes of the future will take place, and no one can say exactly at what point, by income levels, the balance of economic desirability or necessity tilts in the direction of VA care for the user.

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With or without these imponderables, it is clear that a "crunch" is in prospect. But that crunch cannot be met by simplistic, if well-intentioned, decrements to the rest of our health care system.

Let me be specific on that point. I mean to say that the problem, to whatever extent it may exist, cannot and should not be solved by any diminution in the quality of care we provide to all our patients, aged or not. And I mean to say also that the problem cannot and should not be solved by any stratagem that reduces the integrated and comprehensive nature of our health care system.

My views on this are based upon professional judgment, and a consideration of public policy. If quality of care is seriously diminished and if we have less than a completely integrated and comprehensive system, we will have an inoperable system altogether. A system that reduces acute care in order to provide other kinds of care needed by an aging population, is reducing the kind of care that the aged also need, need more than others and need more frequently than others. A system that reduces this particular kind of care, skews the patient population to a point where our affiliations with health professions schools are no longer viable and thus undermines our major guarantor of quality and our principal professional recruitment and retention device. If this sounds familiar as an argument, it is. It is the same argument that we have been making against "mainstreaming" proposals--that by taking away acute care, they would leave us with a system that was no longer viable as a system.

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And if that happens, no veterans, whether aged or not, will derive benefit from the outcome. In short, we must not promise or plan to care for the older veteran through any strategy which disadvantages them and veterans of all ages.

This much, it seems to me, sets the context for the overall approach to these problems. Before setting forth on a statement of current programs for care of the aged veteran and some near-term plans for them, I should like to touch on two specific items. One of them goes well beyond the VA's plans per se and the other has to do with the Geriatric Research, Education and Clinical Centers.

In the first case, I should like to put forward what I believe is a new approach to VA-community interaction. It is based on the evident fact that all the statistics I have cited to you, confined as they are to veterans as actual and potential patients in our system, may seem to bypass the fact that America is "graying." The issue of an aging population and what means exist or must be created to deal with it creates a set of problems not just for the VA but for society as a whole.

It seems to me that we must begin to work with communities all over this country in a variety of ways that recognize that we are a part of the problem (albeit a large part, with an estimate that 60% of all males over 65 in 1990 will be veterans.) It should follow then, that we are only a part of the solution. I think we should, on a local basis, begin to participate in the creation of structures to deal with overall problems of an aging population, many of whom are

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veterans, so that we can work together with the communities to get the best "bang" for both their "bucks" and ours.

We have recently launched, within the Department of Medicine and Surgery, a Medical District Initiated Program Planning (MEDIPP) process which will increasingly rely on planning that comes up to the center from the grass roots. Through this and other means, we want to encourage the growth of such cooperative community considerations on the local level, the initiation of experiments along these lines, and the search for valid interlocutors in the communities where we are located.

It may be, if we succeed in starting and nurturing the growth of such VA-community interactive structures, that both the VA facilities and the communities in which they are located can accomplish more with existing and additional resources than each of us is now doing or can anticipate doing alone.

In regard to this idea, let me note that I am proposing some experimentation in the area of a new Federalism, one which makes use of our resources and knowledge, the resources and knowledge of other Federal agencies, and of the states and communities.

Geriatric Research, Education and Clinical Centers

With respect to the GRECCs, I want to review some of the history and development of the program and then express some views about them and their future, not only as entities in themselves, but also as

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contributors to the general system-wide effort to provide care for the aged veteran.

As to history, the program began in Fiscal Year 1975. Currently, there are eight GRECCs at the following locations: Bedford/Boston, Massachusetts; Little Rock, Arkansas; Los Angeles (Wadsworth), California; Minneapolis, Minnesota; Palo Alto, California; St. Louis, Missouri; Seattle/American Lake, Washington; and Sepulveda, California.

The GRECCs were intended to attract outstanding professionals to teach and to conduct basic and clinical research on aging, to provide education in geriatrics, and to experiment with alternative means for providing care to the aged.

The GRECC concept received increased attention, culminating in Congressional passage of Public Law 96-330, "Veterans Administration Health Care Amendments of 1980." Title III of that law, "Geriatric Research and Care" authorized expansion of the GRECC program up to 15 GRECCs. However, because resources were not forthcoming to make this possible, we have been concentrating on enhancing the extant GRECCs consistent with the Public Law provisions, rather than on creating new GRECCs.

Each Center typically emphasizes one area of research relevant to aging. For example, one has developed a cardiopulmonary function evaluation unit, and four others, all with neuropsychiatric orientation, are focussing on chronic neurological diseases and

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organic dementias, including Alzheimer's type.

The Centers have also begun to make some progress in the provision of clinical care in themselves, as part of the facilities where they are located, and as a stimulus to other parts of the system. I shall have more to say about this aspect of their past and future development when I come to discuss my views a little later in this presentation.

GRECC professionals have produced more than 500 scientific publications since the beginning of the program in FY 1975. GRECCs have reported the award of over $10 million in research funding during the FY 1979-1981 period. About $6 million of this was awarded through the VA merit review process, about $2.4 million in FY 1981 alone. The GRECCs also received awards of approximately $4 million from other Federal agencies and private foundations in the FY 1979-1981 period.

The GRECCs conduct continuing education seminars, workshops, lectures, and other professional and in-service training. Over 30 of the GRECC staff have teaching appointments in academic institutions.

I should like to turn now to an expression of some opinions I have about future developments. First, however, it is important to note that, as you know, the Geriatrics and Gerontology Advisory Committee has been carrying out its mandate to conduct site visits at existing GRECCs and is now hard at work on its report to the Congress concerning its findings and its recommendations. That work is not yet completed and I have no wish to anticipate the report or preempt any of its possible recommendations.

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On the other hand, I have some views that I have formulated independently on the basis of what I know from internal reports and my own observations. The idea of these centers is a good one and some of their accomplishments have much potential for the future.

I believe, though, that if we are going to make the most of them, we should be in a position to direct their operations on a basis that will play to the strengths of the GRECCs, the facilities of which they are a part and the larger professional community where those facilities are located.

I mentioned earlier the launching of the MEDIPP grass roots planning effort. When that was started, I told our directors that I believed that there exists at each of our facilities what I call a "genius of place." I meant that local knowledge and wisdom, local resources and needs, combined to make a unique approach to planning that a Central Office could never have and should never frustrate. In a different context, the same should be true of the operation and evolution of GRECCs. We must recognize the "genius of place" in our GRECCs and be in a position to make of them all that we can.

In order to make that happen, I am convinced that we must be granted more flexibility in management of these centers. In their current, somewhat rigidly defined state, they are most effective in research and in education, neither of which is unimportant to us, and less effective in affecting the delivery of care, which is no less important to us.

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That is not to say that GRECC activities have not been directed toward using existing resources to provide geriatric care and to integrate clinical research and trained providers in geriatrics and gerontology into the VA health care system. For example, as part of the program, GRECCs have been developing Geriatric Evaluation Units (GEU), usually comprising from 10 to 20 beds, for intensive diagnosis and therapy. Six GRECCs have developed GEUs with a broad base in general internal medicine and in psychiatry including one with an emphasis on Alzheimer's disease. Equally importantly, clinical units with special emphasis on geriatrics are being developed in VAMCs that do not include GRECCs. Moreover, GRECCs also provide consultation and conduct geriatric outpatient clinics.

In summary, then, I believe that we are launched upon a good and productive course with the GRECCs and with their potential to act as a "leaven for the loaf" of our entire health care system's ability to care for the aged veterans, and that we need enough leeway and resources to follow through on that course.

Education and Research

Both apart from and in addition to the GRECC programs, a variety of education and research activities directed at the aging population take place throughout the VA health care system. For example, a Geriatric Physician Fellowship Program was established in July 1978 and by 1982, the program reached full scale with 48 physicians in training, and 24 of those completing training each year. This program is conducted in 12 facilities, and four of them are GRECCs.

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To acompany its training for physicians, a program of interdisciplinary team training in geriatrics was initiated in FY 1980. This program includes development and coordination of curriculum components in gerontology at affiliated schools; career development for VA staff; and continuing education for geriatric teams. A Geriatric Dental Program began in 1982 with dental fellows being trained in geriatrics in 5 VA medical centers, two of them having GRECCs. The newly initiated nurse scholarship program has established gerontologic nursing as one of its priority areas. Continuing education efforts are directed at developing staff skills and attitudes necessary for providing quality care to geriatric patients.

In research, in addition to the work already noted, there will be emphasis on investigation of special areas of particular importance to the aged, such as diabetes, chronic ischemic heart disease, chronic obstructive lung disease, schizophrenia, and the development of new and improved sensory aids.

Medical Eligibility for Older Veterans

I shall now turn to some statements about the eligibility of the older veteran population and VA's care programs for it.

There appears to be a belief that older veterans have been given "special" statutory entitlement to VA medical care. In fact, the law does not impose an "inability to defray" requirement on veterans 65 years of age or older in connection with eligibility for VA medical care (38 USC 610(a) (6).

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However, in the absence of some additional statutory entitlement, such as need for care for a service-connected disability, these veterans are not entitled "carte blanche" to care from the VA system. Age alone grants no priority to older veterans over other nonservice-connected veterans. However, medical need criteria must be met for acceptance of older veterans, as it must for all other veterans. Older veteran beneficiaries who claim travel benefits must meet the existing means test--a "poverty oath" of its own--the same as all other veterans without "special" statutory entitlement. Also, older veterans have no special eligibility for contract medical care funded by VA.

Of the 3.3 million veterans we mentioned earlier as the 1981 population pool, 400,000 were service-connected, and 440,000 were VA pensioners. About 100,000 pensioners were receiving an additional allowance for aid and attendance (or housebound benefits.)

As you are well aware, we have for some time been engaged in the painful and slow moving task of "going behind the poverty oath" for under-65-year-old nonservice-connected veterans. That task has still not been completed.

Hospital Care

As has already been clear, the aging veterans does not cease to require acute hospital care. It is important to remember that this need does not occur along a certain continuum in which a patient recieves acute care once and never again.

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Perhaps as a way of gauging the potential buildup of demand for hospital care for the aging veteran, it has been estimated that by 1990, 50% of all beds in VA hospitals will be occupied by those 65 years old or older.

We also provide extended hospital care (or intermediate care) within our hospitals when acute care is no longer necessary for a given patient. The aging factor is important here. For example, while we project that about 27% of patients in VA hospital beds in 1983 will be 65 years or older, about 50% of those receiving intermediate care will be in that age bracket. This intermediate care program provides care to patients who need long-term physician involvement and hospital-based support services. The present number of beds in this program is about 10,000 (10,557). This program serves patients who are not yet medically stabilized and who could not be treated in nursing homes.

In addition to our own hospital care, the VA will assist six States to provide hospital care in seven State Homes to 3,569 veteran patients (590 ADC) in FY 1983. Of those to be provided such care, approximately 71% are expected to be age 65 or older.

Extended Care

The VA's Extended Care programs now encompass a broad spectrum of care for veterans of all ages who need such care and is not a function of care for older veterans per se. The range of programs, in addition to the extended hospital care, or intermediate care already described, includes: Nursing Home Care, which has three components--the VA's own

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Nursing Home Care Program; the Community (contract) Nursing Home Care Program, and the State Home Nursing Home Care Program; the Domiciliary Programs of both the VA and the States: Outpatient Care; the Hospital-Based Home Care Programs, many of which incorporate hospice type services; a Residential Care Program; and one prototype Hospice Program caring exclusively for the terminally ill.

This system of extended care has certain characteristics. The majority of patients enter the system from the acute care hospital system and, if they become acutely ill, are transferred back to the acute care hospital system. The programs are arranged in order of decreasing dependency or to put it another way, in order of increasing rehabilitation. Patients are encouraged to do for themselves and to be involved in decisions about their care. We are concerned with preserving the quality of life of all veterans in the various elements of this extended-care system.

The system calls for balance. In the nursing home care programs, for example, we provide the most intensive care in VA nursing homes. Veterans needing less intensive care, can be transferred to community nursing homes, whether skilled or intermediate care facilities. This program has the advantage of being able to place veterans nearer to their homes and families. We also have the option of transferring patients to State Veterans Home nursing home facilities for extended care. These three nursing home programs give us flexibility and balance. As patient care needs change, we have the ability to transfer patients to a more or less intensive level of care.

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The Department recognizes the need to know more about the extended care medical needs of elderly patients. Two demographic studies are underway to sharpen our projection of the need for such services.

In the interim, prior to the MEDIPP submissions in November of this year, the VA is proceeding with the construction of additional VA nursing home beds. Further, in the MEDIPP context, we are also evaluating where it may be feasible to convert existing hospital care beds.

Nursing Home Care

In FY 1983, the VA will operate 101 skilled nursing home care units with a total of 9,515 average operating beds, to provide care to 14,358 veterans (8,974 ADC). Approximately 62% of the veterans receiving this care will be age 65 or older. During the next five years, approximately 3-4,000 additional beds are projected. Utilization of this program by aged veterans is expected to continue to increase.

Both skilled and intermediate nursing home care will be provided by the Community Nursing Home Program to 29,688 patients (9,395 ADC) in Fy 1983. About 56% will be age 65 or older. To meet the total projected need for nursing home care during the next five years, particularly for the aging veteran, this program will have to be increased at approximately the same rate as the VA Nursing Home Care Program. The Community Nursing Home Care Program, because of the number of homes available, can provide care closer to the veteran's home and can be quickly responsive to changing needs.

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One complaint has been the proliferation of inspections by Federal and State agencies. The VA has an ongoing project with DHHS and State survey agencies directed toward reduction of duplication of effort in the inspection of nursing homes, and toward the improvement of the quality of care in those homes.

The VA will assist 27 States to provide nursing home care in 41 State Homes to 11,934 veteran patients (6,744 ADC) in FY 1983. Of those to be provided care, approximately 73% are expected to be age 65 or older. A 15% increase in patients treated is expected in this program during the next five years.

Domiciliary Care

The Domiciliary Programs calls for the VA to operate 7,778 beds in 16 domiciliaries to provide care to 13,700 patients (7,000 ADC) in 1983. About 30% of those patients will be age 65 or older. Most of the facilities are over 50 years old, and do not meet current standards of fire safety and privacy. It is planned to renovate those facilities, where feasible. There should be 5,851 new or remodeled beds available by the end of the planning period.

Replacement domiciliary facilities were completed and activated in Fiscal Years 1980 and 1981 at the VA Medical Centers in Wood, Wisconsin; Martinsburg, West Virginia; Dayton, Ohio; and Bay Pines, Florida. These facilities were designed at a time when the policy was to construct domiciliaries with the capacity for immediate conversion to nursing homes.

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I must say that a good deal of thought has gone into the question of the domiciliary program. A comprehensive reassessment of the domiciliary program has been completed and we have a new approach to what its mission ought to be.

It will be a program for veterans who have a physical or mental impairment requiring access to continuing care or rehabilitation, but whose condition is such that the regular daily care and services provided by a hospital or nursing home care is not required. We are going to be working with the Associate Deputy Administrator for Construction to develop plans for assuring that all facilities to be used for this program are safe, provide adequate privacy and comfort, and are located in such a way as to provide ready access to a hospital or clinic from which medical care can be supervised and to which the patient may be readily referred if a higher level of care is necessary.

In addition to our own domiciliaries, we will assist 32 States to provide domiciliary care in 43 State Homes to 9,550 veteran patients (4,856 ADC) in FY 1983. Of those to be provided care, approximately 51% are expected to be age 65 or older. A 17% increase in patients treated is expected in this program during the next five years.

Grants for Construction of State Extended Care Facilities

This program assists States to construct new State Home facilities as noted above, for furnishing domiciliary or nursing home care and to expand, remodel, or alter existing buildings for

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furnishing domiciliary, nursing home, or hospital care to veterans in State Homes so that life-safety and other deficiencies identified by the VA and the State can be corrected.

Applications on hand total more than $81 million (VA share) and States have estimated they will submit additional applications of more than $120 million future years. This program is funded at $15.8 million in Fiscal Year 1982.

Outpatient Care

In addition to all these institutional programs, there are several programs designed as alternatives for institutional care. In FY 1983, VA facilities will provide almost 16 million outpatient visits, 157,000 dental exams, and 156,000 dental treatments. About 19% of the outpatient visits will be provided to veterans age 65 or older, but the projected increase for this age group will be substantial, at 62.3%. Outpatient care is also provided in non-VA facilities. Of the 1.9 million medical fee visits, approximately 22% will be by veterans age 65 or older.

Hospital-Based Home Care, Geriatric Day Care, Residential Care Home

Another non-institutional program, the Hospital-Based Home Care Program, is currently operating in 30 VA medical centers. This program provides medical services through 145,000 visits annually (1681 ADC) to homebound patients who otherwise would require institutional care. Another alternative which may facilitate home care is the establishment of geriatric day care centers.

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The VA is exploring the feasibility of these programs. These would provide "day hospital" capability which assists the patients and enable them to carry on rather than being placed in an institution.

The Residential Care Home program provides health care supervision to veterans who do not require hospital or nursing care but who, because of medical or psychosocial health conditions, are not able to live independently and have no suitable family resources to provide the needed supervision and supportive care. The veteran must be essentially capable of performing activities of daily living with minimal assistance. Food, shelter, care, and supervision are financed with the veteran's own resources (often derived from VA compensation or pension) in residential settings inspected and approved by the VA, but chosen by the veteran. The veteran receives follow-up visits from VA health care professionals and is an outpatient of the local VA medical center. Thus, the per patient cost of this program is the least expensive of the extended care programs. Originally begun as a program for the post-hospital care of psychiatric patients, the program is now being developed for the care of medical patients. In FY 1983, we expect to have 12,700 patients in residential care homes.

This completes my presentation. I shall be pleased to attempt to answer any questions you may have.

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TESTIMONY OF GABRIEL P. BRINSKY
AMVETS National Service & Legislative Director
Before The
COMMITTEE ON VETERANS AFFAIRS
U. S. HOUSE OF REPRESENTATIVES
July 14, 1982

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AMVETS appreciates the courtesy and the privilege extended by this Committee to express its views on the health care needs of aging veterans and the geriatric research education and clinical centers.

Because of the time restraints, we will briefly highlight our anxieties concerning this most important issue. We request that our complete statement be incorporated into the record.

Allow me to begin by stating that less than ten years from now two out of every three males in the United States over the age of 65 will be a veteran. It is projected that in less than 20 years there will be more than 8 million veterans when almost one-third of the veteran population will be over 65 years of age. This is worth pondering in terms of need for health care facilities and resources as it relates to the aging population. In this framework of patient potential, we must also accept the fact that older patients require frequent hospital admissions with its longer hospital stays and, of course, more medical attention by physicians. It is common knowledge that the older veteran is more likely to develop more complicated illnesses. The course of diseases in the elderly greatly differ from the manifestations and the course of diseases in young adults. Accordingly, in terms of treatment of the older persons, a modification is required as well as in the administration of drugs used in such treatment in order to relate to their responses. By reason of advances in medicine in recent years, it is possible for patients to withstand diseases such as diabetes, arteriosclerosis, and cardiovascular diseases without prevention or cure of these illnesses.

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Currently, there are eight VA geriatric research, education, and clinical center programs referred to as GRECC. The program was initially established in 1975. Public Law 97-330 authorized the development of seven additional geriatric centers. One of these was planned for Camden, New Jersey, which was scraped. We are concerned that the pressing need in this most important area of health care is being treated with cavalier indifference. Recently, of the 2,000 people working for the Veterans Administration, there was in the neighborhood of 150 people who were employed in the geriatric program. It is evident that the program is not receiving the attention it deserves just as it is patently clear that not enough research is being done on the hospice program for the care of the terminally ill patients. It would appear that these urgent priorities have been relegated to the bottom of the list for the purpose of allocation of resources.

This is not to suggest that the indifference to this most pressing need is due to the Department of Medicing and Surgery of the Veterans Administration. Dr. Donald Custis, the Chief Medical Director of the Veterans Administration, in recent testimony before the Senate Veterans Affairs Committee acknowledged that while Public Law 96-330 authorized expansion of the GRECC program up to 15 GRECCs, the resources were not forthcoming to make this possible.

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We realize that the demands upon the Veterans Administration health care system are many. And we appreciate what Dr. Custis is advocating that we do not overemphasize the need for health care at the expense of the other services provided which will make the system inoperable. But we continue to be of the opinion that time is of the essence. We can no longer delay in setting up the mechanism that will be required to take care of our aging veterans. And unless we begin now, we will not be ready. For much needs to be done, not only in the clinical medicine area but in the realm of innovation and imagination if we are to most effectively treat and take care of our aging veterans. We are awaiting with great anticipation the report and findings by the Geriatrics and Gerontology Advisory Committee which is conducting its studies and will report to the Congress concerning its findings and recommendations.

In our statement, which we have requested be accepted as a part of the record, we have set forth our views and suggestions as to how we can enhance the betterment, in terms of health and care, for our aging veterans.

This concludes my statement. Thank you.

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In our opinion, one cannot view the requirements of the aging veteran without considering the role which the nursing home care centers play in providing that service. In this vein, the VA has projected a construction program of nine nursing home care centers in 1982 with an additional 22 homes in fiscal year 1983 through 1986. The need for these facilities is evident particularly when it is realized that approximately 45% of all the veterans cared for in VA medical centers are more than 55 years of age. And, yet, this modest construction plan presented by the VA will not be achieved by reason of fiscal and other restraints.

As we view the needs of the aging veteran, we must take into consideration the female veteran population which is increasing. While the male veteran population is steadily growing older, there is a decrease in the median age of the veteran women. This gap between the two groups is expected to increase during the next few years. This is bound to impact on the VA medical health care program. A number of scholarly works have been written on geriatric medicine primarily by the Veterans Administration facilities which are engaged in geriatrics and gerontology. Studies have been made on the manifestations and a course of diseases in the elderly. These have been identified as differing greatly from those same diseases in young adults. The need for modification of treatment and the response to diseases in the elders has been identified. Modern medicine has made it possible for the aging to withstand

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certain diseases such as diabetes and atherosclerosis which means that in some ways the elderly are sicker than were the older people in former years.

While there are VA medical centers placing emphasis on certain areas relating to the aging, such as focusing on chronic neurological diseases including Alzheimer's syndrome, it appears that the entire program of medical care for the aging is proceeding in a nonchalant manner. Not enough emphasis is being placed upon it nor is there any sense of urgency in dealing with the subject. We are anxiously awaiting the findings and recommendations of the Geriatrics and Gerontology Advisory Committee which is in the process of carrying out its mandate to report to the Congress after conducting on site visits at the GRECCs. We hope that their recommendations will be hard hitting and will be of value to the Congress. We hope, too, that as a result of these findings the Congress will be stirred into providing whatever legislation may be required in order to engage in a meaningful program of care for the elderly. We also hope that the Committee's findings will result in innovative, creative, and inspiring findings. For in our view, there is much more involved in the treatment of the elderly than merely clinical medicine.

Much is yet to be known about the demands of extended medical care needs of the aging. Many demands will be placed on the VA system. In fiscal year 1983 the VA will operate more than 100 nursing home care units with a total of 9,515 average

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operating beds. To assist it to perform this role, the VA will have 27 states providing nursing home care in 41 state homes to 11,934 veteran patients with the assistance of the Veterans Administration.

We are pleased to see the efforts being made by the Veterans Administration in the overall picture of providing care for the aging veteran: the extended care program through its nursing home care, the community nursing home care, the state home nursing home care, the domiciliary programs, outpatient care, the hospital based home care programs, many of which incorporate hospice type services, a residential care program, and the one prototype hospice program caring exclusively for the terminally ill. While we fully realize that a balanced program for health care of all veterans is necessary in order to obtain the greatest efficiency and quality of care possible, we feel that the various programs for the elderly are not proceeding at a pace sufficiently rapidly to encounter the problems which we face in the immediate future. We fully appreciate that what appears to be procrastination by the Veterans Administration is imposed in action by reason of fiscal restraints. We are cognizant of the many demands placed upon an already overtaxed health care program. And we understand that there is a need to prioritize.

Our comments should not be construed as being critical of the efforts of the VA efforts in this area except to express the impression that we do not feel the VA is moving rapidly enough

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in this area. It is our hope to be able to urge that time be considered more of an essence in this vital field.

We would hope that the Veterans Administration would be the leaders in geriatrics and gerontology just as it was in the years following World War II the leader in vocational rehabilitation for our returning veterans. The field of which we are speaking is not confined to veterans alone but to the entire population. True, a large percentage of that population is made up of veterans. But all of society can profit. The VA has the facilities and the potential to pursue this very vital path in future medicine. We believe it has the facilities which can permit it to conduct this leadership in cost efficient terms. It has the resources to do it.

It would be presumptuous of us to suggest to this Committee various actions which might be taken by the Congress to assist this program until such time as the Geriatrics and Gerontology Advisory Committee has submitted its report. In the meantime, however, we would ask the Committee to be aware of serveral avenues which might be of assistance in the program under discussion. We would urge the expansion of the assistance granted to states to provide domiciliary care. At the present time the VA assists thirty-two states which provide domiciliary care in forty-three state homes. By the encouragement and pursuit of such a program, a greater number of our veterans would be taken care of at less cost to the Federal Government.

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More than 50% of those who are being provided care are 65 years or older. At the present time the Veterans Administration (their share) has applications totalling $81 million and the states have estimated that they will submit additional applications of more than $120 million in future years. This program was funded at less than $16 million in fiscal year 1982. Obviously, this program is being inadequately funded to play any viable part in the health care program.

We would also request this Committee to consider the need for legislation which would provide the older veterans priority in acute or chronic care over other older veterans. Under current legislation, no such priority is given in nonservice connected cases.

Another possible area for consideration by this Committee would be to provide beneficiary travel without the need to meeting the existing poverty oath.

AMVETS will undoubtedly have other recommendations or suggestions to make to this Committee after the Geriatrics and Gerontology Advisory Committee has submitted its report, and we have had an opportunity to study its findings and recommendations.

This concludes my testimony.

PVA
PARALYZED
VETERANS
OF
AMERICA
CHARTERED BY THE CONGRESS OF THE UNITED STATES

STATEMENT OF
GORDON H. MANSFIELD
ASSOCIATE LEGISLATIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
VETERANS ADMINISTRATION HEALTH CARE FOR AGING VETERANS AND THE GERIATRIC RESEARCH, EDUCATION AND CLINICAL CENTERS

July 14, 1982

Mr. Chairman and Members of the Subcommittee, it is a privilege for me to appear today to present Paralyzed Veterans of America's views on the Veterans Administration's plans for meeting the health care needs of aging veterans and on the Geriatric Research, Education and Clinical Centers. It is well recognized that the American population, as a whole, is becoming "older." Care for older veterans has been a great concern of PVA's, and we are especially interested in the effects of aging on individuals who were seriously injured earlier in life.

Information readily shows that the aging of the population in developed countries, including the United States, has become well-recognized in the present century. These studies further indicate that certain significant features of this population aging process must be considered when attempting to project the social needs (including health care), which have arisen or are to be expected.

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First, there has been a reduction of significant disease, disability and death in earlier life. This means the number and proportion of persons reaching old age has been considerably higher. But, there also is a related increasing risk of disease and death as the aging process continues. The resulting consequence is a reasonably predictable increase in the need for a wide variety of health-related services, specifically, for older individuals.

Second, the survival of children to reach reproductive age and beyond has resulted in a rapid population increase, which has been offset by reduced family size. The mistakenly held belief is that the relatively large number of the aged has caused an increase in the ratio of dependent individuals to those in the work force. This has not been true. Factors such as the decrease in the relative number of children, the increase in years worked by individuals, the decrease in the average annual number of days of disability, and increased female labor force participation have combined to maintain, or even reduce, the ratio of dependent individuals to those in the work force (at least until the end of this century). When coupled to increased work force productivity, the aging population should be no more of a social burden than have been other accepted responsibilities in the past.

Third, the average woman has a life expectancy eight (8) years longer than the average man, and is several years younger than her husband. Thus, she will have approximately ten years of widowhood. The absence of a second member of the household is often the determinant of the need for institutionalization. Therefore, there exists a lesser need for institutionalization of men, who are more likely to have an intact family structure.

Fourth, the illnesses of age are predominately chronic rather than acute. Chronic diseases limit mobility and comfort and, as such, are the most frequent causes of institutionalization. Added to this factor is the consideration that only four (4) percent of aged individuals are institutionalized at any time. For most, the terminal illness (acute or chronic) probably will be the only major illness of the lifetime.

And lastly, life expectancy at older age will not continue to increase at past rates. Recently accumulating gerontologic data suggest that large increases in life expectation, based upon disease prevention and cure, are not likely unless the aging process itself can be slowed. Although more individuals reach old age, the fraction which is ill which is ill at any specific age has not increased. It is also likely that once a lethal disease has become manifest, its duration, in old age, has not been greatly lengthened.

These same factors, which have increased the size of the aged population, have also altered social structures. Trends toward urbanization, the decrease in self-employment and smaller families have unfavorably affected the increased numbers of aged persons.

The result is that the perception of the problem as it exsts, (and as it is projected to increase) should lead to prompt planning to overcome the problems our aged population will be facing. The area of health care, especially, requires examination and prompt decisions to ensure that the resources required in the future will be available.

The development of knowledge, technical skills, and complex equipment have improved care and outcome, but at the expense of specialization and fragmentation in the medical field. Any program which is developed must contain provision both for accessibility to available and necessary resources and continuity of care for both acute illness and chronic disease through convalescence to health and maximum independence.

Health care needs of persons at any age require a range of services from periodic evaluation of the essentially well individual through the complex requirements of the acutely ill, life threatened patient in the modern intensive care unit of a hospital. There are many gradations of services, which lie between the above-mentioned extremes. The aged are subject to a number of health problems, which are characteristic of and are related to age or the aging process. Although the frequency of these diagnoses increases, the number, which may afflict any one individual, and their intensity, are widely variable. Also, although many of the problems of aging are the result of chronic processes, much can be done to relieve the effects. However, the combination of increased incidence of disease, the development of effective but complex therapies, and the slower recovery time of the aged combine to require more frequent and prolonged hospitalization.

Veterans currently comprise over 40 percent of all American males over the age of 20 years. There were a total of 29,974,000 veterans in civil life as of May 1982. This figure includes 25,569,000 wartime service veterans. The age grouping of veterans is presented in the table below. This breakdown represents veterans population figures as of March 31, 1981 and indicates periods of service in the Armed Forces of the United States.

ESTIMATED NUMBER OF VETERANS IN CIVIL LIFE, BY AGE AND PERIOD OF SERVICE
March 31, 1981

(In thousands)

Age	Total Veterans	WAR VETERANS							Post-Vietnam Era 4/	Service Between Korean Conflict and Vietnam Era Only
		Total 1/	Vietnam Era		Korean Conflict		World War II 3/	World War I		
			Total 2/	No Service in Korean Conflict	Total 2/ 3/	No Service in World War II				
ALL AGES	30,129#	25,560#	9,081	8,750	5,805	4,647	12,301	482	1,144	3,045
Under 20 yrs.	77	-	-	-	-	-	-	-	77	-
20-24 yrs.	1,121	283	283	283	-	-	-	-	828	-
25-29 yrs.	1,908	1,764	1,764	1,764	-	-	-	-	204	-
30-34 yrs.	3,750	3,703	3,703	3,703	-	-	-	-	29	18
35-39 yrs.	2,985	2,204	2,204	2,204	-	-	-	-	6	783
40-44 yrs.	2,406	782	494	482	300	300	*	-	*	1,844
45-49 yrs.	3,105	2,546	284	64	2,482	2,477	5	-	*	339
50-54 yrs.	3,880	3,829	180	14	2,097	1,741	2,070	-	-	35
55-59 yrs.	4,603	4,397	97	3	318	103	4,489	-	-	6
60-64 yrs.	3,325	3,329	35	1	283	19	3,355	-	-	-
65-69 yrs.	1,500	1,500	17	*	99	7	1,485	-	-	-
70-74 yrs.	704	704	3	*	34	*	704	-	-	-
75-79 yrs.	183	183	-	-	10	*	178	5	-	-
80-84 yrs.	282	282	-	-	2	-	52	240	-	-
85 yrs. & over	242	242	-	-	*	-	3	237	-	-
Average Age 5/	47.2	49.5	33.8	32.6	50.7	48.8	60.0	84.8	23.0	41.7

NOTE: Excludes an estimated 142 (thousand) who served only between World War I and World War II, all of whom are 63 years of age or older, and 239 (thousand) who served only between World War II and the Korean conflict, all of whom are 45-59 years of age.

1/ Veterans who served in both World War II and the Korean conflict, and in both the Korean conflict and the Vietnam era, are counted once.
2/ Includes 331 (thousand) who served in both the Korean conflict and the Vietnam era.
3/ Includes 1,158 (thousand) who served in both World War II and the Korean conflict.
4/ Service only after May 7, 1975.
5/ Computed from data by single years of age. The average age of veterans in each period of service as of March 31, 1981 is equal to or less than the comparable mean age on September 30, 1980. This is due to an inadvertent overstatement by about 0.5 year in the average age figures as of the end of fiscal year 1980.
There are also 110 living Spanish-American War veterans whose average is 101.0 years.
* Less than 0.5 (thousand).

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The historic pattern of American wars has created increased numbers of veterans at roughly generational intervals. As a result, there is a concentration of veterans who will pass through various ages together as they grow older. Most of the World War I veterans were aged 65 to 75 years between 1960 and 1970, aged 75 to 85 between 1970 and 1980, and the survivors over age 85 will be most numerous between 1980 and 1990. The World War II - Korean War veterans will have similar age concentrations between 1985 and 1995, 1995 and 2005, and 2005 and 2015, respectively. Since this is a uniquely large group, and the needs of the aged change during these three periods, projections for health service facilities require a recognition of these variables.

Because of the large numbers of veterans of World War II and the Korean War, by 1990, more than half of United States males, over age 65 years, will be veterans, and by 1995, veterans will exceed 60 percent of the total male population.

Factors which the VA has indicated as important, in planning for providing service to these individuals, are:

- veterans will comprise the major portion of the male aged population for the remainder of this century;

- in general, the characteristics of the veteran population will lie close to the mean for all males of the same age;

- to the veteran the VA is a comprehensive health service resource provided as a prepaid benefit and available as eligibility is achieved. It represents a catastrophic or last resort source of care for all veterans who do not use the VA routinely;

- as a significant portion of the total aged population, whatever health services resources exist or are planned for the aged are also accessible to the veteran, and must be considered in program planning for the aged veteran.

While there will be a significant increase in the veteran demand for services between the present time and 1990, the really significant surge in demand will come subsequently because of the increasing number of extremely old veterans. As late as 201 there may be more than a million veterans over the age of 85 years, compared to 130,000 at present. Should current rates prevail, they alone might require over 250,000 nursing home beds. These will be in addition to substantial numbers of slightly younger veterans, also aged and requiring medical care. While projections to 1990 provide reasonable long-term objectives, planning for the next decade (to 2000) cannot be neglected by the VA.

Another problem which must be addressed is the need for the VA health-care system to adequately provide for the female veteran. A VA study has found that women who are former members of the U.S. armed forces numbered 742,000 as of September 30, 1981. This number represents 2.5 percent of all living veterans. The study also indicates that the number of female veterans has increased by 26 percent in the past five years. Current expectations are that the number of women in the armed forces will very likely continue to grow by significant numbers. The expected result is that the female veteran population will grow steadily in future years. The study showed that as of September 1981, the median age for female veterans was 46.2 years as compared to 50.3 years for male veterans. These statistics have implications which must be addressed by the VA on a nationwide basis.

These statistics indicate that while the total veteran population will be decreasing, the proportion of aged veterans will be growing. And, among aged veterans those in the higher age categories will also be increasing. These facts require that the VA address the problem immediately, so that the needed health-care services will be available in the future. This is especially important when the increased need of these services by aged veterans is considered. Clearly, the aging veteran population will have an enormous impact upon the VA health-care delivery system. The VA can expect an increase in demand and a resulting larger number of hospital discharges. Since the aged veteran remains longer, a disproportionately larger number of hospital beds will be required to meet this projected need.

Regardless of how the VA expands to meet this demand, the change in age distribution of those patients treated will affect the system. There will be a different mix of patient diagnoses, medical specialties and hospital beds; more surgeries and more dependent patients.

The typical VA hospital patient will not only be older, but will be a patient with more complex problems requiring additional care. He will require more staffing and more resources. Not only will 58 percent of hospital discharges involve older veterans, but they will probably consume significantly more than 58 percent of available resources.

The VA has developed a model of graduated levels of patient care needs, which can be readily identified. This model as outlined in Senate Committee Print Number 12, A Report On The Aging Veteran, January 5, 1978 is:

Level 0 (no disability): Individuals at this level are essentially well and need no services. They should have access to and take advantage of periodic examinations to rule out and treat nascent and otherwise unrecognized disorders, particularly those with serious potential. Older individuals, just as the very young, should receive appropriate immunizations.

Level 1 (minimal disability): These are patients with established diagnoses, which require periodic services, especially visits to the physician's office or a clinic, but are otherwise able to maintain an independent lifestyle.

Level 2 (mild disability): These are patients who require a greater level of support, because of disability, but only on an intermittent basis. Additional requirements may include transportation, assistance in shopping, or housekeeping.

Level 3 (moderate disability): At this level the patient requires someone in the household daily, but not necessarily continuously. Examples include patients with arthritis or significant residuals of a stroke, as well as many psychiatric patients in remission.

Level 4 (moderately severe disability): These patients require the constant availability of support and supervision, but relatively little actual performance of services. Examples include certain types of cardiac patients, such as those convalescing from a myocardial infarction, or patients with severe brain damage who cannot be alone.

Level 5 (severe, chronic, stable disability): Includes those patients who require intensive non-professional nursing care. A typical and frequent example is the stable, but totally incapacitated, aphasic patient with the residuals of a stroke. Usually, this is the highest level for a skilled nursing facility.

Level 6 (severe, chronic, unstable disability): These are patients who require frequent, even daily, medical supervision, extensive skilled nursing care, and many of the services generally available only in the hospital. Most of these patients are unstable, and can be expected to improve or to get worse over a period of months. Examples include patients recovering from severe accidents or complex surgical problems, patients with severe respiratory diseases, patients in the terminal phases of cancer, and patients with severe neurological disorders, such as traumatic paralysis of all four extremities.

Level 7 (acute disability or diagnosis): This level represents traditional acute hospital care. The hospital provides specialized facilities for diagnosis and treatment not readily available in an alternative setting, and the utilization of specialized services is high. Nursing care can vary from minimal to intense. The duration of stay at this level is usually relatively short.

Level 8 (severe acute disability): Patients in this category are critically ill, with need for intense use of all hospital services and facilities. The typical setting includes the intensive care, coronary care, respiratory care and surgical intensive care units. The general ward also continues to serve many of these patients. The duration of stay tends to be brief, with early transfer to a less intense status.

The VA must consider in its planning of care for aged veterans that the combined effect of a decline in the size of the veteran population, and an increase in the number of veterans over 65, will cause a significant increase in the demand for VA health-care services. VA information indicates that the inpatient discharge rate for veterans over

65 is three to four times that of veterans under 65. Also, the outpatient visit rate for those veterans over age 65 is twice that of veterans under age 65.

Other factors which the VA must consider in its planning are:

- Disease rates increase with age and account for the higher utilization rates among older veterans. There are significant differences in diagnoses by age. With an older patient population, the VA can expect increased work loads in certain areas and decreased work loads in others. For example, there should be decreases in the number of psychiatric discharges and a significant increase in the number of non-psychiatric discharges.

- Closely related to diagnoses is the medical specialty associated with each discharge. Specialties such as urology, ophthalmology and gerontology are weighted toward older patients, whereas psychiatry and neurosurgery favor the younger patient. An older patient population will significantly affect the medical specialties required in the future.

- Differences in diagnoses and medical specialties imply different bed section requirements. The older veteran tends to utilize a higher proportion of medical and surgical beds, whereas the younger veteran uses a higher portion of psychiatric beds. The end result will be a substantial increase in the number of discharges from medical and surgical beds and a decrease in those discharged from psychiatric beds.

- The absolute number of diagnoses per patient is higher among older veterans. These multiple diagnoses are but one of many indicators showing the increased complexity associated with the older patient.

- The likelihood of having surgery is higher in older patients. In addition, the conditional probability of having multiple surgeries given that one surgery has occurred is higher in older veterans. As a result, the VA health care system can expect to perform more surgery in the years ahead.

- The degree of independence is less in older veterans. Independence may be defined as a patient's ability to feed, bath, dress, walk or transfer himself, or combinations of these. Decreased independence in older patients will substantially increase staffing requirements in the years to come.

- The source of hospital admissions varies significantly by age. Younger veterans have a higher percentage of direct admissions. Older veterans have a higher portion of admissions from nursing homes, outpatient clinics; and domiciliaries. The projected increase in VA nursing home beds will also have an impact upon the VA hospital system since a sizable number of nursing home patients will also have a hospital discharge which will generate additional patient days.

- The place to which a patient is discharged reflects the veteran's age. Older patients have a higher chance of being discharged to a nursing home, domiciliary, or hospital based home care program. Younger veterans are more likely to be returned to the community at-large. Thus, the hospital stays of older veterans tend to generate additional demand for nursing home care and other programs.

- There are many other factors which vary by age and affect demand for VA health care. These include former prisoners of war (approximately 95 percent of POW's are older World War II veterans with above average physical and psychological problems), compensation and pension status (service connected veterans have significantly higher utilization rates that increase with age), marital status (family support systems reduce utilization), and income (lower income for older veterans increase utilization of VA facilities.)

The factors involved in the aging process above indicate a definite need for additional health-care services for the aging population. Since the VA must address the specific needs of aging veterans, PVA believes an assessment of the VA health-care system is necessary in attempting to determine the future needs and changes within that system.

The following is a brief description of programs available to the aging veteran with definitions of the various programs as used by the Veterans Administration.

Hospital Programs

The General Medical and Surgical (GM&S) Hospitals

GM&S hospitals constitute the primary system through which the VA provides health care for eligible veterans. Within the hospital are provided intensive and routine diagnostic and therapeutic services, corresponding to levels 6, 7 and 8 previously defined. There are currently 144 GM&S Hospitals in the VA system.

Extended Hospital Care

A special development within the VA has been the recognition of and provision for intermediate care patients, now to be redesignated Extended Hospital Care (EHC) patients. These are defined as patients who have passed through the acute stage of their illnesses, but who are still unstable and will require several months of further hospital care before a stable course can be anticipated. These patients continue to need a high level of skilled nursing, frequent to daily physician supervision, inhalation therapy, physical and other rehabilitative therapy services, speech therapy, and other professional services, and the availability of hospital-based laboratory, x-ray, and other diagnostic and therapeutic systems. Some of these patients, such as those with terminal cancer, will die; others will recover; and some will become stable and require more permanent placement. These patients conform to level six. In FY 1967 only 1,504 beds were so classified, but by 1977 the number had increased to 10,456. This VA capability has been increased because patients who have exhausted other entitlements or funds as the result of catastrophic disease or injury are often referred to the VA because this level of need is inadequately met by the private sector.

Psychiatric Hospitals

Several important developments have modified the recent approach to psychiatric hospitalization. First, improvements in psychiatric therapy; second, the advent of a large variety of psychotropic drugs which have made it possible for many psychiatric patients to function independently; third, a recognition of the poor rehabilitation potential of geographically isolated institutions; fourth, the recognition that psychiatric care is more effectively delivered when it is on a service of a general medical and surgical teaching hospital; fifth, a change in philosophy which has encouraged returning many psychiatric patients to the community; sixth, the great expansion of outpatient resources and treatment organizations.

As a result of these changes, the number of VA psychiatric beds has been reduced from 54,345 in 1967, to 28,173 in 1977. During this period the annual number of admissions increased from 71,076 to 161,969. This change has been associated with veterans' increased attendance at mental programs. The total number of these visits increased from 753,553 to 1,613,974 annually. The number of psychiatric hospitals has decreased from 41 to 28, as these institutions have broadened services and been converted to a GM&S mission. The psychiatric services in GM&S hospitals had only 12 percent of the psychiatric beds in 1967: They now have 60 percent. Comparable changes have occurred in other sectors of the health services system.

The more efficient use of psychiatric beds has increased the efficiency of the VA system and contributed to the present increase in available beds. However, it is not clear how much further this trend can continue.

Institutional Extended Care Programs

Nursing Home Care

Nursing Home Care for veterans is authorized under Public Law 88-450, enacted in August 1964. Care is provided to eligible veterans in VA, community, and state nursing home facilities. The nursing home accommodates patients who are not acutely ill and not in need of hospital care, but who require much skilled nursing care and a lesser amount of medical and related health services for a protracted period of time. The goal of nursing home care is to provide a framework of therapeutic services for restoring patients to optimal health. These patients are commonly aged and infirm, and the nursing home is often their last residence. Nursing home care is most applicable to patients in categories four and five, but may be applicable to some patients in category three as well.

VA Nursing Home Care (VANHC)

VA Nursing Home Care (VANHC) beds are established adjacent to full service VA hospitals. Veterans admitted to this program usually have little or no potential for outplacement in other VA Extended Care or community facilities because of the high level of nursing care required. There are more patients at level 5 than is usual in community nursing homes. Veterans requiring nursing home care and treatment for service-connected disabilities have priority for admission to VANHC. Length of stay is contingent on an individual's need for care and is not time-limited.

Community Nursing Home Care (CNHC)

The community segment of the nursing home program (CNHC) provides care in nursing homes which are widely dispersed throughout the country. This program is intended for the veteran whose condition or whose level of satisfaction would be improved through the placement in the supportive environment of his own community near family and friends. These are proprietary homes, approved after inspection, which will accept veterans on a per diem contract. Veterans requiring community nursing care for a service connected condition may receive such care at government expense indefinitely, but care is limited to six months for non-service-connected veterans.

Domiciliary Care

Domiciliaries represent the original programs in the Veterans Administration and derive from 1866 legislation which established Soldiers Homes for disabled veterans. Originally, the Homes were converted barracks and there was little intent to provide medical care. During World War I some medical facilities were created, and these became more developed when the Veterans Bureau became the Veterans Administration in 1930. Enactment of Public Law 293 in 1946 increased the emphasis on medical services with the establishment of the Department of Medicine and Surgery, but the domiciliaries continued essentially as a protected residential program. The present sixteen domiciliaries perform a role comparable to the homes for the aged, but, in addition, provide a protective environment for a large number of younger men who have residual psychiatric disabilities. This latter group is largely socially malfunctional, and domiciliary care provides an effective but less expensive alternative to psychiatric hospitalization. Limited psycho social and medical programs are available. In addition, most domiciliaries have access to the medical facilities of the associated hospital. Domiciliary care fits into levels one, two and three.

State Veterans Homes

The State Veterans Homes program has grown from 11 homes in 11 states in 1888 to 40 State Homes in 31 states including the District of Columbia. Currently a total of 15,815 beds are available to provide hospital, nursing home and domiciliary care. The VA relationship to State Veterans homes is based upon two grant programs. One is a per diem program which enables the VA to assist the states to provide care that meets modern standards of quality to veterans requiring domiciliary, nursing home, and acute and intermediate hospital care. The other grant program provides VA assistance with 65 percent federal funding in the construction of new domiciliary and nursing home care facilities and the expansion and remodeling of existing facilities. The State Home per diem program is administered through VA medical facilities which reimburse the states on a quarterly basis. The construction program is administered by VA Central Office.

Since the enactment of Public Law 88-450 in 1964, VA grants have been utilized by 22 states for construction projects for nursing home beds. Public Law 91-178 made it possible for the VA to participate in the remodeling of existing hospital and domiciliary facilities. The provisions of Public Law 95-62 enabled the VA to continue to assist states with new construction funding and expanded the construction program to include domiciliary facilities.

State homes offer a veteran institutionalization in the state of his birth or residence in proximity to his family and friends. Seventeen of the 40 homes and two annexes accept veteran-related dependents. This helps provide a more normal atmosphere in the home (as opposed to an all male population). It also makes it possible to avoid separation of a family unit. Veterans in State Homes usually contribute toward the cost of their maintenance in the home.

State home domiciliaries differ from VA domiciliaries in that the care is strictly residential, i.e., the provision of food, shelter, incidental medical care on an ambulatory basis and special rehabilitative programs. State nursing homes provide skilled nursing care and related medical services. Except for licensed nurse staffing, they must meet State and community nursing home standards. Of the eight state home hospitals four are accredited by the JCAH and two by Medicare. While all of them provide intermediate hospital care, six also provide acute care usually limited to non-surgical intervention.

Non-Institutional Extended Care Programs

Personal Care Homes

The VA Personal Care Homes were originally devised as a means of discharging psychiatric patients into the community by providing a basic level of social support in a family setting. This is now the largest VA Extended Care Program, with over 22,000 veterans in placement. The potential of this program for the placement of older veterans, who are without families of their own, has not been fully explored. This is an alternative which appears to be worthy of consideration in planning for future VA programs for aging veterans.

Hospital Based Home Care (HBHC)

Patients with significant residual disability may be helped to remain in their own homes through the Hospital Based Home Care program (HBHC). The patient and his family are provided the necessary instruction in the routine and nursing procedures under the coordinated supervision of the hospital based treatment team, consisting of a physician, public health nurse, social worker, rehabilitation therapist, dietitian and nursing assistants. At present there are HBHC teams at 30 hospitals. Social and emotional supports help maintain the patient in the community. The frequency of home visits is determined by the patients' needs and the treatment plan. A potential which has not yet been fully developed is the prolonged maintenance of patients with terminal malignancies. Under proper conditions HBHC can be utilized for selected patients up through level five. HBHC is an outpatient program and has had less funding priority than the inpatient programs. No new programs have been initiated since 1974. HBHC is authorized by Public Law 93-82.

Congregate Housing

Congregate housing provides a living arrangement for a group of semi-independent persons who are provided with such services as meals, transportation, assistance with personal care, and laundry. Such a program may include single persons or couples living in separate units within the same complex, or a group of single persons sharing the same living unit. The goal of this program may be to enable elderly persons to remain in the community as long as possible, or it may be used as an outplacement resource enabling the resident to achieve increasing independence. This type of program seldom has been utilized by the VA. Its use to date has been mainly for psychiatric patients who need a protected living arrangement with some support, but who do not need the close supervision provided in a personal care home. This program may be a resource which can be expanded as an alternative for veterans seeking hospitalization due to failing ability to maintain themselves in the community without support, for hospitalized patients unable to return to a more independent mode of living, or for some veterans applying for domiciliation.

Geriatric Day Care

Geriatric Day Care is suggested as an alternative approach to treating a selected group of aged veterans with physical and mental disabilities. The number of patients with potential for such placement is not known. Selected patients from categories two through four should be eligible. Patients with advanced intellectual deterioration would not be expected to benefit, but those with moderate deterioration could be accepted, particularly if this would relieve the "caretakers" sufficiently to make home placement possible. A VA program is perceived as one which would reach the socially isolated and physically handicapped. Objectives would be to provide stimulation and socialization activities in a supervised environment, provide patient and family education, and offer family caretakers relief from the stress of continuous care of the patient. Ideally, the program should operate over a 10-hour day to accommodate working families. It should not duplicate already existing community services for which the veterans are eligible. The success of geriatric day care will depend greatly upon the transportation services that can be made available.

Senior Centers

Senior Centers are not part of the VA program, since no authority exists for the provision of non-medical services. However, the socialization which these centers provide can improve the quality of life, and indirectly reduce the disability of chronic physical and psychiatric disorders. In addition, the centers can provide health, education and preventive services. Thus, within the limits of authority, the VA encourages and assists the development of these programs.

This Subcommittee, the Congress, and the VA have taken tentative steps in reviewing the above numerated services and options for caring for aging veterans through the creation of Geriatrics Research, Education, and Clinical Centers.

PVA is especially concerned about programs such as The Geriatrics Research, Education, and Clinical Centers, and believes they need to be made a viable part of the VA health care system. Public Law 96-330, the "Veterans' Administration Health-care Amendments of 1980," became law in August 1980, when Congress resoundingly overrode a Presidential veto of the legislation. It is likely that a great deal of Congressional support came because of the proposal's establishment of additional geriatrics centers. Administrative action had already created eight geriatric research, education, and clinical centers within the VA and Public Law 96-330 stresses that these are to be adequately funded before the new centers are to be established.

PVA is very grateful to this Subcommittee, the full Committee, and to Congress for giving the geriatrics program the validity of law, rather than relying on Administrative discretion. However, we are concerned that commitment to authorizing such centers is not being met by a corresponding commitment to funding them. The FY'83 VA budget fails to provide for any new geriatric centers.

It is well established that the average age of the nation's veterans is increasing to the point where many feel they are no longer needed by their families, society, and the nation. This corresponds with the physiological problems faced by millions of older Americans.

A true commitment to the VA's geriatrics program would benefit veterans and all Americans, alike. Representative Claude Pepper provided some observations in the October 2, 1979, Congressional Record which are worthy of repeating. Eleven percent of the American population is made up of persons over age 65, and 25 percent of all suicides in the United States are committed by members of this group. Also 20 percent of all persons in the nation who suffer from alcohol-related problems are in this same age group. It is known, too, that approximately 100 reversible conditions result in the same characteristics as does senility.

Despite determined efforts by Representative Pepper and other Members of Congress, the nation's elderly have not received appropriate consideration in our national priorities: gerontology receives approximately 1 percent of the budget of the National Institutes of Health, and only about 2 percent of Medicare funds go to mental health care coverage for the elderly. The low amount of total Medicare funding for mental health services arises because the program pays only a maximum of $250 annually per recipient for outpatient treatment of mental illness and, unlike its 20-80 co-payment for physical illness, there is a 50-50 co-payment. (Eighty percent of the Medicare funds which do go for mental health services are expended for institutionalized care.)

The VA, and the nation as a whole, presumes that the individual becomes disabled upon reaching age 65. The VA's policy is reflected in the extension of health-care services and pension benefits to certain veterans based upon the controlling criteria of low income and attainment of age 65. Many private employers likewise assume that the individual's usefulness terminates at age 65. In short, federal and social policies reflect the need for geriatric research and counseling, especially when productive individuals are induced into or forced into retirement.

Closely related to the lack of emphasis in the VA's geriatrics program is a pending shortage of domicilary and nursing home facilities. Despite the need for expanding these facilities, there appears to be little commitment to increasing them by a significant number to a satisfactory level. Furthermore, the VA is running behind schedule in constructing the relatively small number of bed spaces which have been authorized.

The VA and the Office of Management and Budget plan to reduce the number of operating beds within the Department of Medicine and Surgery. PVA strongly recommends expansion, not reduction, of the number of such beds. It seems wasteful and doubly counter-productive not to convert these into long-term care beds. PVA recognizes that in some cases the existing facilities are structurally unfit for any kind of health-care use. Often, though, operating wards are merely closed and taken out of service while the rest of the facility continues to provide useful medical functions. We are appalled that operating beds are completely removed from the system and are not being converted to fill the need for long-term care.

In short, the VA's geriatrics program must be adequately funded and expanded, and there needs to be a corresponding growth in VA nursing home and domicilary facilities to care for older veterans.

PVA trusts that the VA's Geriatrics Research, Education, and Clinical Centers will be expanded, and that special awareness will be given to the effects of aging on disabled veterans. An example of this need, which we have seen repeatedly, is when a healthy paraplegic develops cardiovascular difficulties in his older age. Veterans with lesser disability ratings also are likely to experience accelerated age-related health problems because of disabilities sustained early in life.

PVA also believes the special needs of the aging SCI veteran must be addressed in planning for VA health-care delivery in the future. In the "PVA Response to Spinal Cord Injury Program Plan FY1980-1987", dated March 15, 1980, PVA noted that the VA proposed to expand the SCI service nation-wide from 18 centers with 1,386 beds to 23 locations with 1,565 beds. On a level-of-care breakdown this would provide 236 beds (15%) for intensive rehabilitation, 845 beds (54%) for sustaining care and 484 beds (31%) for long-term care. PVA concurred that an increase in SCI beds was required and PVA has supported an increase in the percentage of long-term care beds from approximately 25 percent of total SCI beds to the projected level of 31 percent of total beds. This support reflects PVA's realization that, as the SCI veteran population ages, the need for long-term care beds will increase. PVA now requests that the special needs of the aging SCI veteran be specifically included in planning for future VA facilities.

PVA's Research Program has been working with Dr. Juan Fonseca, VA Director of SCI Service, on developing current information of the SCI veteran population. The information as it becomes available, and projections based upon this information, should greatly assist the VA in this area.

There are a number of significant findings which should be highlighted in any discussion of the needs of aging veterans. Most SCI veteran respondents to questionnaires, which PVA mailed to 97,889 potential spinal cord injured veterans, served in World War II (51%) and are over 50 years of age (64%). Sixty-four percent (64%) of all the SCI respondents are service-connected disabled veterans, while thirty-five percent are non-service connected. The most positive finding from the survey responses was that 67 percent use VA facilities. Unsurprisingly, 97 percent of all SCI respondents were men. The largest group of responding females served in Work War II. These results do not differ greatly from those reported for the general veteran population.

One finding which does differ from general veteran population trends was the geographical distribution of the SCI veteran. The top ten states of residence for veteran respondents, compared with that of the general veteran population, are:

SCI RESPONDENTS		GENERAL VETERANS POPULATION	
California	- 10.0	California	- 11.2
Florida	- 6.8	New York	- 8.1
Texas	- 5.9	Pennsylvania	- 5.8
New York	- 5.6	Texas	- 5.5
Pennsylvania	- 4.9	Illinois	- 5.1
Ohio	- 4.9	Ohio	- 4.9
Michigan	- 3.2	Florida	- 4.5
Illinois	- 3.0	Michigan	- 3.9
Massachusetts	3.0	New Jersey	- 3.7
Wisconsin	- 2.6	Massachusetts	- 2.9

Other pertinent facts learned from the SCI veteran respondents are also presented:

TOTAL SCI RESPONDENTS:

Disability:

Paraplegic - 36%
Quadriplegic - 11%
Polio - 10%
MS - 41%

Sex:

Male - 97%
Female - 2.6%

Use VA Facilities:

Yes - 67%
No - 32%

Marital Status:

Single - 12.0%
Married - 68.0%
Widowed - 3.8%
Separated 2.6%
Divorced 13.0%

Period of Service:

World War I - 1%
World War II - 51%
Korea - 19%
Vietnam - 20%
Peace - 6%

Compensation & Pension:

Service - 64%
Non-Service - 35%

Age:

-30 - 3.3%
31-35 - 8.0%
36-40 - 8.1%
41-45 - 5.0%
46-50 - 10.0%
50 over - 64.0%
under 50 - 35.0%

PVA urges that consideration be given to the establishment of additional satellite clinics for out-patient treatment. This recommendation is based upon the above-mentioned large population increases in all areas of the state. PVA urges that the inclusion of SCI outpatient clinics be considered when planning for these proposed satellite facilities. Special SCI clinic days at these facilities with appropriately trained SCI health-care personnel available would alleviate some of the special problems of travel associated with SCI patients.

The VA studies on aging veterans, coupled with the information from the SCI Registry Report, lead to several conclusions. PVA believes the VA must act immediately to properly plan for, and implement, methods of dealing with the health-care needs of aging veterans. The methods chosen must be those that can be most easily implemented within reasonable cost constraint, and must be available when needed.

PVA believes there already exists a definite, well-known need for additional SCI beds in the VA health-care system. SCI units in VA medical centers in Palo Alto, California, Tampa, Florida, and Houston, Texas, are being utilized at maximum capacity today. PVA regularly receives information about SCI veterans, who are unable to schedule required annual examinations in a timely manner. Other reports indicate the need to cancel some scheduled admissions when current patients are not discharged on time, or when emergency admissions preempt scheduled bed space. Additionally, many SCI veterans are admitted, or transferred, to other wards. When this occurs, the SCI veteran is cared for by less experienced personnel, who are not familiar with SCI patient care techniques. Some SCI Services have experienced problems in attempting to get SCI patients admitted to, or transferred to, other wards within the hospital.

PVA believes that one cause of this problem is the extra requirements for nursing care that SCI patients require. PVA has testified previously on the rigorous, more time-consuming care required in SCI units and the need to provide more adequate pay for the dedicated nuring care personnel who continue to work on these units. PVA believes that this is a primary cause of the high turn-over rate of nursing care personnel on SCI units which is a major problem in some VAMCs. This problem also affects the physicians who staff SCI units. These are the individuals within the VA health-care system that must explain to a high level quadraplegic with symptoms of dangerous medical problems that no room exists in the SCI unit, or even in the hospital. Continuous exposure to this type of situation will adversely affect the VA health-care delivery system.

PVA believes that the facts available now indicate the need for additional SCI Centers in the VA Hospital system. The indications of demographic changes presented in the VA studies on aging veterans and the SCI Registry Report must be considered by the VA in planning for future resources. PVA believes that there is an obvious need for SCI services throughout the VA health-care system.

PVA has identified some possible solutions to the problem of VA provision of high quality health care to aging, and SCI veterans, in the State of Florida. Some of these solutions should be used by the VA in planning for future needs on a nation-wide basis. PVA believes that the establishment of additional satellite clinics, which could be located outside the currently established maximum distance from VAMCs, should be adopted by the VA. These satellite clinics could possibly be co-located with Department of Defense installations or stations under the proposed VA-DOD Sharing Agreements, which are to be implemented. In instances such as this, the use of DOD supplied resources such as space, medical diagnostic or treatment equipment, maintenance, and transportation could be utilized by teams of VA health-care personnel who would examine and treat the patients. Combinations of physicians, registered nurses, rehabilitation therapists, and others could provide traveling units to visit designated locations at specific intervals. A number of these teams with different emphasis on medical specialties could travel a "circuit" visiting a different location each day of the week. In this manner a satellite clinic could present care for aging veterans with a Geriatric's Specialty Team on one day, for heart patients with a Cardiac Specialty Team on another day, for SCI veterans with an SCI Specialty Team, and so on. This concept would be a cost-saving measure because the reimbursement for traveling long distances by each veteran which would be saved, combined with the use of DOD supplies, equipment, and facilities, would offset the small cost of transporting the VA Specialty Team to the different locations. PVA supports this concept and requests that the VA do further studies of its feasibility.

PVA believes an expansion of the Hospital Based Home Care program described above would significantly improve the VA's capability of delivering high quality care to aging veterans. PVA has a number of members who have utilized this program to improve their quality of living. PVA believes that every consideration should be given to placing eligible veterans in this program. Those veterans whose medical condition has stabilized and have the necessary family support to enter this program should be encouraged to do so. The VA should also consider the possibility of additional cost-savings from a program such as this which removes the veteran from the VA hospital to his own home. Also, the establishment of satellite clinics may provide a possible method of expanding this program geographically.

PVA also supports extending the Fee Basis Home Health Care Program. This, again, is the type of VA program that is cost effective and provides quality health care to the veteran. PVA supports efforts such as this program in an attempt to provide the best possible health care to the largest number of veterans at the lowest cost. PVA believes programs such as this allow catastrophically disabled SCI veterans to maintain a viable home environment in the community. The result is greater personal satisfaction for the veteran and less cost to the VA and the the taxpayer. PVA believes this program could serve as a prototype for the provision of services to a significant number of aging veterans.

PVA also requests that the VA consider expanding the range of services provided through programs such as Independent Living Centers, Congregate Housing, and Geriatric Day care. Each of these programs is a cost-effective method of dealing with special medical requirements of the patients involved. PVA believes that the VA must consider programs which might currently be outside the range of services or systems of delivery now used when planning for the future needs of aging veterans.

PVA has worked closely with certain parts of the VA such as the SCI Service in attempting to solve problems and develop plans for the delivery of high quality medical care at a cost-effective price. PVA will continue this co-operation in ensuring that aging SCI veterans as well as all veterans are provided the health care services they are entitled to receive.

Mr. Chairman, that concludes my testimony. I will answer any questions I can.

Statement of

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by

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and

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THE AMERICAN LEGION

before the

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
U. S. HOUSE OF REPRESENTATIVES

on

THE AGING VETERAN

JULY 14, 1982

STATEMENT OF JOHN F. SOMMER, JR., DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES
JULY 14, 1982

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to present its views to the Subcommittee on the subject of Veterans Administration Programs for aging veterans.

Mr. Chairman, we commend you and the Members of the Subcommittee for taking up this subject. The problems that will confront the Veterans Administration between now and the year 2000, in dealing with the aging veteran population are massive. They will require, not only conceptual and strategic planning by VA, but most definitely will require legislative support by the Congress. Never in the history of veterans affairs in our nation has the Government had to manage a problem of this nature and this scope. The existence of the problem itself, of course, is the result of the fact that the United States has engaged in four wars in the Twentieth Century, and in doing so has created a veteran population in excess of 30 million, most of whom served during World War II, between 1940 and 1946.

The American Legion does not have the capability to develop the conceptual planning necessary for this problem. We have been, and we will continue working with both Congress and VA to evaluate, appraise and lend our best judgment to the work of the professionals who are involved in this effort. We are in the role of consumer advocate, and we are attuned to and responsive to the needs and desires of the veteran population.

To define the scope of the problem, let us first set forth a few of the pertinent statistics - trying at the same time to avoid burying ourselves in a wealth of numbers. The statistics we offer are from the VA Office of Reports and Statistics.

There are today 12 million veterans between the ages of 50 and 65. The average age of the WW II veteran today is 60.5 years. By September 30, 1986 there will be 5.5 million veterans over the age of 65. By September 30, 1991 this figure will rise to 7.8 million. The peak year for WW II veterans over age 65 will be 1992, when there will be 7.9 million of them. By year 2000 there will be 9.2 million veterans of all wars who are past the age of 65. In 1981 the mortality rate for WW II veterans was 250,000 per year.

And, to further place our remarks in context with the problem, let us offer the following figures from the VA Department of Medicine and Surgery.

In the VA system, there are on line today 9,287 nursing home care beds. The monthly turnover rate in these beds is 5%, and the Bed Occupancy Rate is 95%. By the end of Fiscal Year 1987, VA plans to have on line 13,100 nursing home care beds. Planned to come on line during FY 1982 are 480 beds; FY 1983, 348 beds; FY 1984, 480 beds; and FY 1985, 320 beds. It must be added that all NHC beds planned for beyond FY 1983, are subject to the revalidation process initiated by the Administrator.

In the area of Domiciliary facilities, there were on line as of May 31, 1982, 8,243 beds, with an Average Daily Patient Census on that date of 7,164. Future planning for the Domiciliary Program waits on reports within the Medical District Initiated Planning Program (MEDIPP) that is now underway in DM&S. We shall have a few words to say about the Domiciliary Program before the conclusion of our remarks.

Our statistics on the Nursing Home Care Beds do not include beds now available or planned for the Contract Nursing Home category. That program appears to fluctuate depending on local need as against availability of VA operated nursing home care beds.

As of today, combining nursing home care and domiciliary, there are 17,530 long-term care beds available within the VA system. There are also on line 10,557 intermediate care beds. This number has not varied appreciably during the past five years. Intermediate care beds do serve an important purpose in freeing up beds for patients experiencing acute episodes of illness.

We stated at the beginning of this presentation that we commend the Subcommittee for addressing the problem of VA programs for aging veterans, and we do. However, it would be our suggestion that beyond this oversight examination, the Committees of Congress should undertake no definitive planning for the future of VA programs for aging veterans until the Committees are in receipt of a report from the Geriatric and Gerontology Advisory Committee that was established under the legislative authority of Public Law 96-330, the Veterans'Administration Health-Care Amendments Act of 1980. Among the commendable features of that Act, which had the support of The American Legion, was establishment of the GGAC. The members of the GGAC were appointed by the Administrator as of May 1, 1981, and have been functioning since that time. The legislation mandated that within the membership of the GGAC should be a representative of a veterans organization. An American Legion representative was chosen by the Administrator for that assignment, and has been working with the Committee.

The Geriatric and Gerontology Advisory Committee will submit its first report to the Administrator in the near future. That first report, and future reports will include specific recommendations for consideration by Congress, in planning for care for aging veterans. The Committee membership is composed of persons with outstanding credentials in the field of Geriatrics and Gerontology. The Committee can and will provide expert assistance to the Committees of Congress, and it would be our recommendation that definitive planning should wait on the results of the work and the recommendations of the GGAC.

It should also be mentioned that PL 96-330 mandated the establishment, within the Department of Medicine and Surgery, of the position of Assistant Chief Medical Director, trained and experienced in the field of geriatrics. This has been done, and that office is now functioning in DM&S.

Let us speak now to the current perception of The American Legion as to the problems of VA care for aging veterans.

It is clear that the impact of the aging veteran population is already beginning to be felt by VA, as witness, among other things, the 95% ADPC of the Nursing Home Care Units, and the fact that practically all of them have waiting lists.

Acute care beds within VA are already seeing more of the catastrophic illnesses that are associated with advancing age, such as heart disease, stroke and malignancies. We believe VA is dealing with these as well as it can, with its present resources, and recognizing that the maximum level of anticipated impact yet lies ahead.

It cannot be said the VA Department of Medicine and Surgery has not done planning and instituted initiatives with reference to aging veterans, as witness the planned increase in nursing home care beds and the eight current Geriatric Research, Education and Clinical Units. It is to be noted that a total of 15 of these GRECCs are authorized by Public Law 96-330, although funding for the additional seven has not been provided.

Our observation in visiting the current GRECCs with the GGAC is that some of them are marginally funded, and thus, the extent of their efforts is limited.

Without wishing to supersede the conclusions of the GGAC, which are yet to be formulated, we would say the current impact of the existing GRECCs is limited by their funding, and perhaps by the absence of more detailed guidance and support from Central Office. That the GRECCs are doing some good is definitely true. They are carrying out innovative and effective programs in the three areas of research, education and clinical care - perhaps the latter most modestly. It would seem to this observer that perhaps it is now time for Central Office to provide guidance and support that would lead to the implementation of GRECC proven approaches to geriatric medicine more comprehensively throughout the VA system. In other words, it would be good if what the GRECCs are doing - that has been so far proven effective, could be extended to the practice of medicine on the general care wards of the medical centers. The GRECCs have now been functioning for some eight years. It is time, it would seem, that more patients could share the beneficial effects of what the GRECCs have learned.

It is our belief also that more funding and encouragement, from Central Office and from Congress could and should be directed to the research efforts of the GRECCs. Basic research in the field of geriatric medicine is much needed - by the general field of medicine; and VA, as it has in some other fields, such as hypertension, could be a leader in this area, in part because of its increasing aged clientele.

We will not extend our remarks in this direction, because we, too would like to wait on the findings and recommendations of the GGAC.

The American Legion is very supportive of such programs as Hospital Based Home Care and the Foster Home Program. Our observation is that Hospital Based Home Care is a popular program with the professionals who are engaged in it. It seems to be accepted in medicine that it is better to treat and maintain the patient in a home atmosphere than in the sterile surroundings of the hospital. The problem with Hospital Based Home Care is to make the program cost-effective. In most places the teams operate only within a fifty mile radius of the medical center. But they do much good. The teams are enthusiastic about their work, and their patients are happy to be at home with their families. This is also true for the Foster Home Program, where the patient lives - at his own expense in a foster home, and is medically managed by the medical center.

These programs are community oriented, and are in line with current thinking in medicine that it is better to maintain patients de-institutionalized as much as, and for as long as possible. All of this ties in with the accepted postulate that quality of life is an essential ingredient of life itself.

If the forward movement of the practice of medicine in the VA Department of Medicine and Surgery is toward providing care for the veteran as much as possible in a de-institutionalized setting, then this is going to create problems for both VA and Congress. The question is going to be - can community based programs be made cost-effective - and can the nation afford them. We of the Legion support the theory of maintaining the veteran patient in the community as much as and for as long as possible. We recognize too, that there are limits to what the Government can afford, even in the application of advanced principles in the practice of modern medicine.

The only practical approach we see to this matter at present is for the Congressional Committees to work with VA, and with the Congressionally mandated Geriatric and Gerontology Advisory Committee, to develop programs that answer the needs of aging veterans, within the parameters of accepted medical practice in today's world; put cost figures to these programs, and then determine what the Government can afford, and perhaps how the projected programs can be adjusted to make them affordable.

The fundamental proposition put forward by The American Legion in a discussion of this nature is that the Government of the United States must not and cannot turn its back on the aging veteran population.

That is not what the young men and women of 1940 were told when they were sent forth to conquer Hitler and Tojo. What they were told was that if they would go out and win their war - their Government would never forget them. Franklin Roosevelt and the leaders of Congress in 1940 did not say "We will never forget you - until you get old - and then we will forget you, because then you will be too expensive."

That thought, Mr. Chairman, leads us to address the fact that some leaders in this Government, both in the Executive and the Legislative Branches have been making statements that the Government cannot, in fact provide care for all the veterans who are now reaching and passing the age of 65. We will tell you frankly that the Administrator has said to American Legion groups that there are too many veterans 65 years of age, and the Government cannot afford care for them all.

The American Legion reaction to that statement is hostile. We have tried to point out to the Administrator that nobody has ever said or expected the Government to provide care to all veterans who are 65. What the law says is that veterans who are 65 are entitled to care when needed and applied for, without regard to their ability to pay for such care - to the extent that VA resources are available. Please note carefully the final clause of that statement. To the extent that resources are available.

In the first place, more than half the veteran population has never applied for VA medical care - and never will. Most veterans take care of themselves - just like all other citizens. Those who can be expected to apply for VA care are those in the lower economic categories who are suffering with catastrophic illnesses. The American

Legion works in all 172 VA hospitals - every day. If there are any millionaires in those hospitals - we have yet to see them. Most millionaires, when they become ill - rent the finest suites in the best hospitals that money can buy - why would they want to go to a VA hospital, where they would have to associate with poor people?

Based on his public statements, it is our opinion the Administrator either does not understand the laws and regulations that govern the VA medical care program, or that he does not accept their philosophical rationale.

The American Legion wants the present VA medical care program to be maintained, first for the service disabled, and then for those veterans who need and apply for care from the VA system. Our position is consonant with the commitment first made to the nation's war veterans by Congress, when it passed the World War Veterans Act of 1924. Congress has taken no action to rescind that commitment. To the contrary, Congress, through the many years since 1924 has adopted a plethora of legislation to expand, modify and improve the VA medical care program, until it has become what it is today, the finest single comprehensive medical care program in the nation.

The American Legion never expected, nor intended the VA system to be large enough to accommodate 25 million war veterans. In the main, the VA system has done what it was intended to do. It has provided care for the service disabled, and beyond that, for those who have found it necessary to turn to VA for care. The National Academy of Science study of 1977 found that the active clientele of the VA system comprises about 3 million of the 30 million veteran population, and that the overwhelming majority of these are single, elderly and poor. Sixty-six percent of them were found to have no health insurance.

Having stated our fundamental beliefs in this regard, let us return then to accommodating these beliefs to the particular problems of the aging veteran - which will comprise the largest segment of the veteran population for the foreseeable future.

We believe VA should move rapidly now into the forefront of the practice of geriatric medicine. We believe the thrust of the VA effort should be toward maintaining the veteran patient for as long as possible in a community setting. This will require bold and innovative thinking, and pioneering efforts toward leading the entire nation into the new field of geriatrics and gerontology. For it is not only the veteran population that is getting older. With advancing longevity, the entire American people are getting older. Modalities developed for care and treatment of veterans will, in many instances be applicable generally, and VA can be a leader, just as it has been in other areas of medical science.

We realize the cap on all this will be what the Government can afford. We do not expect unrealistic commitments by the Congress. Most veterans will continue to care for themselves, as they have always done. They will use their entitlement to Medicare - and for those who need it, Medicaid. But there will be those who will turn to the VA system. We of the Legion certainly do not want the VA system, at this juncture, to be reduced in size. That is why we continue to seek to persuade VA not to reduce its bed capacity any further than it has already done. We are sure the demand for bed service will increase, as more older veterans are stricken with catastrophic illness.

Among the innovative approaches, we would like to see VA move forward in the hospice - or palliative treatment area. This is an acceptable aspect of medical practice and will become increasingly important.

The American Legion supports the Domiciliary Program. We do not want to see it materially reduced from its present level. The point is that there will continue to be some veterans who, by reason of physical condition, income limitation and psychological adjustment, will need the security of an institutional atmosphere. VA now has introduced therapeutic approaches to try to prepare these veterans for a successful return to community living. The American Legion supports that therapeutic effort, and will assist it in every way possible. But we do not want VA to turn its back on those who need institutional support.

It is true that many older veterans suffer from alcohol abuse. This is certainly not peculiar to the veteran population, since alcoholism is endemic among the American people. Alcoholism is an identified pathological condition that is susceptible to treatment. Veterans with alcohol problems are ill, just like anybody else. VA has done pioneer work in treating this problem, and Congress has been supportive - to its credit. We support the treatment programs in VA medical centers, and we support the Halfway House program, authorized by Congress, and which assists the recovering alcoholic to return to the community in a physically and economically viable condition.

In summary, let us say that VA is doing many things in the area of development of programs for the care of aging veterans. Congress has been supportive, for which The American Legion is grateful. Much more needs to be done. There will be advances in medical science and technology in caring for the aging. New modalities will be developed, with the thrust toward the continuance of community living. In the long run, with the funding support that will be necessary, we believe all these developments will be cost-effective, in that they will keep more older citizens, including veterans, in a productive capacity during their later years. In all of these activities, most certainly, compassion and caring must be factors. This nation must not turn its back on the young men and women who fight its wars, when they become old. The sacrifices of Iwo Jima and the Normandy Beachhead are as valuable to the nation now as they were in 1944.

The American Legion has said, and says again that the nation that forgets its war veterans is in danger of losing its soul. We do not believe that is going to happen in our country.

Thank you.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

STATEMENT OF

DONALD H. SCHWAB, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO THE HEALTH CARE NEEDS OF
AGING VETERANS AND THE GERIATRIC RESEARCH, EDUCATION AND CLINICAL CENTERS

WASHINGTON, D. C. JULY 14, 1982

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you for the privilege of appearing before this distinguished Subcommittee to present the views of the Veterans of Foreign Wars of the United States.

My name is Donald H. Schwab, and it is my privilege to serve the more than 1.9 million men and women of the Veterans of Foreign Wars as their National Legislative Director.

Mr. Chairman, the Veterans Administration extended care program is tailored to the needs of older veterans and embraces long-term care in VA and community nursing homes, domiciliary care, hospital-based home care, residential care, all care in State Homes facilities, and the Geriatric Research, Education and Clinical Care Program. The necessity for these programs is quite evident since the Veterans Administration is going to be faced with an unprecedented older veteran population. There are presently 3.2 million veterans 65 years of age and older, and according to "A Report on the Aging Veteran", Senate Committee Print No. 12, 95th Congress, 2nd Session, this age group will peak at eight million in 1995. As we have previously stated, it is not anticipated

World War II veterans will inundate the VA Health-Care system. However, there will, no doubt, be an increased demand for geriatric care and it would behoove the VA to accelerate preparations in this area of care.

Mr. Chairman, Public Law 97-72 requires the Administrator of Veterans Affairs to maintain not less than 90,000 hospital and nursing home care beds over which he has direct control and such other beds as deemed necessary to fulfill the VA's contingency responsibility to the Department of Defense. Presently there are 80,163 operating hospital beds and 8,988 nursing home care beds. The average daily census for hospital beds has consistently remained at approximately 80 percent of capacity and for nursing home care beds, the average is presently 93.4 percent. More than 70 percent of the veterans receiving nursing home care in VA facilities are in receipt of either compensation or pension. Unfortunately, it continues to be most difficult to gain admittance for a veteran to nursing home care. In view of the fact that approximately 17,000 hospital beds remain empty, the VFW suggests, as we have before, that a portion of these empty beds be converted to nursing home care beds which are going to be even more in demand in the next several years.

In addition to the foregoing, nearly 9,000 veterans are receiving nursing home care by VA contract with community nursing homes and more than 6,000 veterans are cared for by State Home Nursing Care Units. Therefore, approximately 24,000 veterans are receiving nursing home care funded in whole or in part by the Veterans Administration.

Mr. Chairman, the VA presently operates 16 domiciliaries for predominantly older and ambulatory veterans in need of professional care, but neither hospitalization nor skilled nursing care. Approximately 70 percent of the average 8,000 residents in domiciliaries are in receipt of compensation or pension and their average stay is approximately four years. The VA program in preparing veterans to return to community living is highly commendable and significantly reduces the occurrence of domiciliary residents becoming institutionalized. The VFW believes this program fills a very definite need and not only should be continued, but expanded due to the increasing number of aging veterans who may need such care. Thirty-seven State Home domiciliaries provide similar care to approximately 5,000 veterans.

As a matter of record, Mr. Chairman, the VA hospital-based home care program was established by Public Law 93-82, approved August 12, 1973 and is encoded as 38 USC 612(a). In addition to providing home health services to chronically ill veterans, when the Administrator deems it necessary or appropriate, he may also authorize structural alterations of the veteran's home to include lavatory and sanitary facilities not to exceed $2,500. This is a good and cost-effective program which, unfortunately, has not been expanded due to the absence of adequate funding. Twenty-six VA Medical Centers presently participate in home-based health care and the last activation of such units was in Janaury 1974.

Mr. Chairman, the Residential Care Program provides room, board, personal care and general health care supervision to veterans not requiring more skilled care but, who because of health conditions are unable to resume independent living and have no suitable family resources. This care is provided in private homes selected by the VA and paid for in full by the veteran. The VA is unable to establish uniform standards for such homes due to the variance in state and community laws. These homes fulfill a very definite need at minimal cost to the VA. However, the success of individual homes is contingent upon the adequate staffing of VA social workers. Residents receive outpatient care at local VA facilities. Unfortunately, there are no provisions in existing law allowing the outplacement of indigent veterans to this type care.

Mr. Chairman, the VA's Geriatric Research, Education and Clinical Centers Program (GRECC's) is a matter of great concern to the VFW and one we believe is, unfortunately, being given short-shrift. One of the provisions of Public Law 96-330 authorized expansion of GRECC's from the present eight to as many as 15. Funding was to have been $10 million in the fiscal year 1981 and $25 million each of the following three fiscal years. Notwithstanding the obvious and growing need for expansion of the GRECC's, no money has yet been appropriated for this purpose. Pointing out the slow progress in this program, you will recall that the proposed new facility in Camden, New Jersey, was first reduced in size and then canceled. The smaller facility was to have been a model Geriatric Center. The proposed funding for the eight existing GRECC's merely adds three employees to bring the staffing level up to authorized standards. In my testimony before the Subcommittee on HUD-Independent Agencies of the House Appropriations Committee earlier this year, I pointed out the absence of funding to expand the GRECC Program and the crucial need which was recognized by Congress when, on the same day, both the House of Representatives and the Senate overrode the President's veto of the enacting legislation.

Mr. Chairman, presently 32 states operate some 45 State Veterans' Homes which are the beneficiaries of two VA grant programs. Under the first, the VA will financially assist the funding for construction of new nursing home and domiciliary facilities or the renovation of existing ones with a grant of 65 percent of the cost. Under the provisions of 38 USC 641, the other grant program pays each state per diem in the amount of $6.35 for domiciliary care, $12.10 for nursing home care and $13.25 for hospital care for each veteran. State Homes provide a highly cost-savings supplement to VA extended care programs. The VFW has historically supported both grant programs before this and other committees in both houses of Congress. S. Con. Res. 92 allocates $10 million in fiscal year 1983 for grants for construction of State Extended Care facilities. This is a reduciton from $15.8 million in the current year and it is our understanding the VA has requests on hand from various states in excess of $81 million.

Public Law 96-22 established a five-year pilot program of preventive health care services for veterans with 50 percent or more service-connected disability ratings and for veterans receiving treatment involving a service-connected disability, using interdisciplinary health-care teams. This program was to receive the maximum funding of $10 million in the fiscal year 1980, $12 million in 1981, $13 million in 1982, $14 million in 1983, and $15 million in 1984. No funding has been specifically appropriated for this program and VA information sources indicate only a "dribble of money" has been provided for this program.

Mr. Chairman, one of the provisions of Public Law 96-466 provides a four-year pilot program of independent living and assistance for severely disabled veterans for whom vocational rehabilitation is not reasonably feasible. The pilot program is limited to 500 veterans and requires the Administrator to submit a report to Congress by September 30, 1984 with respect to its effectiveness. It is my understanding that although the law has been in effect for 20 months, only 17 veterans are participating in the program. As a matter of fact, on the 17th of June the VA issued a news release captioned "VA Seeks Veterans for New Independent Living Services Program."

Mr. Chairman, you know that the VFW is highly disturbed by the freeze placed on 56 construction projects by the Administrator of Veterans Affairs for the purpose of revalidation. Although we are reasonably certain most of the projects will be revalidated since they were fully justified by the VA and approved at the appropriate level established by law, we fear some projects will be deferred and repeated deferment ultimately leads to cancelation due to escalating costs. Among the construction projects being revalidated are eight nursing care units and two domiciliaries which are obviously greatly needed.

Mr. Chairman, it serves no useful purpose for the Congress to authorize programs related to the health care of veterans and, then, fail to adequately fund those same programs. However, if the VA under duress from the Office of Management and Budget fails to request appropriate funding, the Administrator should be the one held accountable. The VA budget for the fiscal year 1983 at $23.8 billion is 3.09 percent of the Federal budget of $769.8 billion in outlays, the least it has been in recent history. The VA simply cannot continue to receive less and less of the Federal budget and fulfill the nation's commitment to our wartime veterans. As graphically illustrated in the House Veterans' Affairs Committee Print No. 74, dated March 15, 1982, veterans' programs and health care are not ones breaking the bank. In summary, Mr. Chairman, if the GRECC program, the Preventive Health-Care Program, the Independent Living Program, and the Construction and State Grant Programs were fully funded considerably more and substantial progress could be made in fulfilling the health-care needs of older veterans.

Mr. Chairman, also appended to my testimony are resolutions passed by the voting delegates to our last National Convention which are pertinent to the subject of this hearing as follows:

Resolution No. 621 --	"VA Plan for Aging Veterans"
Resolution No. 717 --	"Matching Fund Construction Grants to States"
Resolution No. 721 --	"Non-Expiring Nursing Home Care for WWI Veterans"
Resolution No. 781 --	"Support Legislation to Improve VA Delivery of Geriatric and Extended Health Care Services"

This concludes my testimony, Mr. Chairman, and I will be happy to respond to any questions you may have. Thank you.

Resolution No. 621

VA PLAN FOR AGING VETERANS

WHEREAS, the Veterans Administration has already sustained disproportionate budgetary and personnel cuts; and

WHEREAS, operating hospital beds have been slashed from 121,000 in the 1940's when there were 15 million veterans to a planned patient census of 64,000 in F.Y. '82 with a veteran population of 30 million; and

WHEREAS, from 1990 on, more than half of all American males over 65 will be veterans with an undetermined number requiring some classification of extended care; and

WHEREAS, Congress has recognized the nation's responsibility to improve and expand the capability of VA health care facilities to respond to the needs of an increasing number of older veterans by passage of P.L. 96-330, which is stymied by OMB's refusal to provide funds for its implementation; and

WHEREAS, there has been a demonstrated reluctance by medical schools affiliated with the VA to address this special need and incorporate it into their teaching program as a medical specialty; and

WHEREAS, the Veterans Administration must of necessity revise its current configuration of health care and other services to meet the demands imposed by this growing population of aging veterans; now, therefore

BE IT RESOLVED, by the 82nd National Convention of the Veterans of Foreign Wars of the United States, that the Veterans Administration provide the Congress with a comprehensive plan to meet the needs of the aging veteran.

Adopted by the 82nd National Convention of the Veterans of Foreign Wars of the United States held in Philadelphia, Pennsylvania, August 14-20, 1981.

Resolution No. 717

MATCHING FUND CONSTRUCTION GRANTS TO STATES

WHEREAS, the Congress of the United States has continuously provided medical, domiciliary, and nursing care to the nation's veterans; and

WHEREAS, the Veterans Administration has worked with many states to develop hospital, domiciliary, and nursing care facilities to provide care for the veterans; and

WHEREAS, many of the states with financial support from the Veterans Administration have provided hospital, domiciliary, and nursing care to veterans in cooperation with the Veterans Administrations; and

WHEREAS, there is a continued need to provide nursing care to the nation's veterans above and beyond the level that can be provided by individual states or the federal government, however, in a joint venture these services can be expanded to the older veterans; now, therefore

BE IT RESOLVED, by the 82nd National Convention of the Veterans of Foreign Wars of the United States, that we go on record requesting the Congress to provide increased funding to the Veterans Administration for the purpose of matching state funds to expand the state veterans hospital, domiciliary, and nursing care services; and

BE IT FURTHER RESOLVED, that the Veterans Administration shall negotiate from time to time the Veterans Administration reimbursement costs to states for care of such eligible veterans.

Adopted by the 82nd National Convention of the Veterans of Foreign Wars of the United States held in Philadelphia, Pennsylvania, August 14-20, 1981.

Resolution No. 721

NON-EXPIRING NURSING HOME CARE FOR W.W.I. VETERANS

WHEREAS, PL 96-151 authorized the veterans of World War I and Mexican Border Campaign the same privileges as the veterans of World War II, Korea and the Vietnam Era for outpatient treatment and other medical benefits; and

WHEREAS, these benefits authorized outpatient treatment for the World War I and Mexican Border Campaign the same as the service connected veterans but not nursing home care on a non-expiring contract; now, therefore

BE IT RESOLVED, by the 82nd National Convention of the Veterans of Foreign Wars of the United States, that Title 38 United States Code be amended to permit indefinite outplacement of World War I veterans to community nursing homes operated under VA auspices.

Adopted by the 82nd National Convention of the Veterans of Foreign Wars of the United States held in Philadelphia, Pennsylvania, August 14-20, 1981.

Resolution No. 721

Resolution No. 781

SUPPORT LEGISLATION TO IMPROVE VA DELIVERY OF GERIATRIC AND EXTENDED HEALTH CARE SERVICES

WHEREAS, the demand for geriatric and extended health care and medical services being placed upon the VA is rapidly increasing; and

WHEREAS, by 1980, there will be nearly 3 million veterans 65 years of age or older; by 1985, there will be almost 5 million such veterans; and by 1990, this figure is projected to jump to over 7 million veterans 65 years of age or older; and

WHEREAS, the VA has instituted a Geriatric Research, Education and Clinical Centers Program (GRECC), to "... give visibility and respectibility to geriatrics and, by creating centers of interest and activity, exploit available old resources and develop enthusiastic new practitioners, teachers, and researchers in the field;" and

WHEREAS, the VA hospital system should be the leader in geriatric research, training, and care, due to the extensive network of VA facilities and the scope of medical care now provided; now, therefore

BE IT RESOLVED, by the 82nd National Convention of the Veterans of Foreign Wars of the United States, that we go on record and urge the expansion of the VA's role in the delivery of geriatric health care service to meet head-on the documented need of such health care services.

Adopted by the 82nd National Convention of the Veterans of Foreign Wars of the United States held in Philadelphia, Pennsylvania, August 14-20, 1981

Resolution No. 781

AMERICAN ACADEMY OF OPHTHALMOLOGY

OFFICE OF
GOVERNMENTAL RELATIONS

Suite 300
1101 Vermont Ave., N.W.
Washington, D.C. 20005-3570
(202) 737-6662

July 15, 1982

The Honorable G.V. Montgomery
Chairman
House Committee on
Veterans Affairs
2184 Rayburn House Office Bldg.
Washington, D.C. 20515

Dear Rep. Montgomery:

On behalf of the American Academy of Ophthalmology I am pleased to note that the House Committee on Veterans Affairs is holding oversight hearings on the increasing health care needs of our nation's aging veterans. We respectfully submit the attached written statement for inclusion in the hearing. Our statement underscores the need to identify and plan for the diagnosis and treatment of diseases and problems of the aging eye, as part of the Veterans Administration's overall strategy to meet the demands that are being placed on its health care delivery system as our veterans enter their retirement years.

We will be happy to provide additional information at your request.

Sincerely,

Charles Sonneborn

Charles B. Sonneborn
Director

Enclosure

POLICY STATEMENT

AMERICAN ACADEMY OF
OPHTHALMOLOGY

EYE CARE IN THE VETERANS ADMINISTRATION

Policy:

The American Academy of Ophthalmology supports the concept of a unified eye service in the Veterans Administration at both the Central Office and health care facility levels.

Background:

Such unified eye care models are cost effective and efficient and exist in the federal and private sectors. Within these models non-medical personnel report to the Chief of Ophthalmology. An example of this at the federal level is the Uniformed Armed Services.

At the private provider level, examples include the majority of health maintenance organizations (HMO). There are generally two formats for eye care delivery within such HMOs. In some, such as the Kaiser-Permanente Health Plans and Group Health Association of Washington, D.C., there are separate departments of Ophthalmology and Optometry with the Chief of Optometry reporting to the Chief of Ophthalmology for the coordination of eye care policy. In others such as the Group Health Plan of St. Paul, Minnesota and the Harvard Community Health Plan, there is a single eye department under the direction of a Chief of Ophthalmology.

Evaluation:

Such a unified service would include both medical and non-medical health care providers, and would be coordinated by a Physician Director, Eye Service, in Central Office. Ophthalmologists, optometrists, opticians, and auxiliary personnel, such as technicians and technologists, would be included.

At the health care facility level, both ophthalmologists and optometrists would be professionally and administratively supervised by a Physician Coordinator of Eye Care.

In those facilities where there is an ophthalmologist, this coordinator should be an ophthalmologist. In those facilities without an ophthalmologist the coordinator should be a designated physician.

(over)

Pursuant to V.A. Circular 10-81-33 (Treatment and care of eye patients), "The responsibility for the overall treatment of each patient lies with a physician who coordinates the treatment and care rendered by various physicians, non-physician specialists and support staff... In accord with defined privileges, optometrists may render care to patients with ocular disease under the supervision and with approval of an ophthalmologist or the primary designated physician."

A single eye care service would assure the best quality care. It would be the most cost efficient means of accomplishing the above stated policy (10-81-33), and would avoid multiplicity of similar services and clinic facilities.

Developed by: Secretariat for Governmental Relations

Approved by: Board of Directors, 10/3/81

GLOSSARY

OPTICIAN:	An optician is a technician who makes, verifies and delivers lenses, frames and other specially fabricated optical devices and/or contact lenses upon prescription to the intended wearer. The optician's functions include: prescription analysis and interpretation; determination of the lens forms best suited to the wearer's needs; the preparation and delivery of work orders for the grinding of lenses and the fabrication of eye wear; the verification of the finished ophthalmic products; the adjustment, replacement, repair and reproduction of previously prepared ophthalmic lenses, frames and other specially fabricated ophthalmic devices.
OPTOMETRIST:	An optometrist, while not attending medical school, is a health service provider who is involved with vision problems. Optometrists are specifically educated, trained and state licensed to examine the eyes and to determine the presence of vision problems. Optometrists determine visual acuity and prescribe spectacles, contact lenses and exercises. Optometrists are qualified to perform all services listed above under opticians.
OPHTHALMOLOGIST:	An ophthalmologist is a physician (doctor of medicine or doctor of osteopathy) who specializes in the comprehensive care of the eyes and visual system. The ophthalmologist is the only practitioner medically trained and qualified to diagnose and treat all eye and visual system problems. Each is licensed by a state to practice medicine and surgery. Thus, an ophthalmologist is the only provider who can deliver total eye care (i.e., "vision services", contact lenses, medical eye care, and surgical eye care) as well as diagnose general diseases of the body. The ophthalmologist has completed four years of college pre-medical training, four years or more of medical school, one year of internship and three or more years of specialized medical training and experience in eye care.
REFRACTION:	Refraction is measurement of the optical state of the eye.
VISION SERVICES:	Vision services are refractive and optical services delivered by ophthalmologists, optometrists and opticians. These services include an examination of the eye for corrective lenses and the supplying and dispensing of glasses and contact lenses if required.
VISION CARE:	Vision care is a term commonly used to describe vision services when provided as part of insurance and other third party payment programs.

TOTAL EYE CARE:	Total eye care refers to vision, medical and surgical eye services provided by an ophthalmologist. Included as an integral part of total or comprehensive eye care are refractive and optical services.
APHAKIA:	Aphakia is the absence of the lens of the eye, usually resulting from surgery to remove cataracts.

Approved: Board of Directors
American Academy of Ophthalmology
6/26/81

POLICY STATEMENT

AMERICAN ACADEMY OF OPHTHALMOLOGY

THE ROLE OF OPHTHALMOLOGY

Policy:

All evaluations which claim to diagnose eye disease should be carried out by or under the direct supervision of a physician. An ophthalmologist is a physician with specialized medical knowledge of the visual system.

Background:

Ophthalmology, the branch of medical science concerned with the structure, functions and diseases of the eye and visual system, dates from antiquity. As a science and art, ophthalmology has often been on the leading edge of progress in medicine. Some of the oldest effective therapeutic agents were used to combat eye disease, and operation for cataract was one of the earliest procedures. For over a century a thorough understanding of optics, refraction and binocular vision have been recognized as crucial to the practice of ophthalmology and, indeed, the original scientific studies illuminating these subjects were all made by ophthalmologists. The American Board of Ophthalmology was the first specialty board in the United States, pioneering the way for what has become the accepted method of certifying postgraduate specialty training in medicine throughout the world. Thus, not only has ophthalmology always been a part of medicine, it has also been one of its most progressive specialties.

The practice of ophthalmology has historically encompassed all aspects of visual function in health and disease including refraction, orthoptics, binocular vision and strabismus as well as medical and surgical treatment of disease involving the visual system.

The general practice of ophthalmology is predominantly a medical specialty, consisting of medical eye examinations and optical and medical therapy of ocular visual abnormalities. The average ophthalmologist examines 100 patients per week and performs 50 refractions.

Evaluation:

For the ultimate benefit of the American public, a clear distinction should be made between a diagnostic vision examination and an examination for purposes of refraction. A diagnostic vision examination involves the practice of medicine and requires the highly specialized training of a physician.

1833 Fillmore / P.O.Box 7424 / San Francisco / California 94120 / (415) 921-4700

A refractive examination involves the taking of measurements of the visual system which is simply a data gathering procedure and involves no medical expertise.

The utilization of ancillary personnel to perform certain nonmedical procedures or tests is appropriate as a means of enhancing the productivity of ophthalmologists and thereby increasing the availability of ophthalmologists to provide medical services and to provide the highest level of comprehensive vision care to the greatest number of individuals. The ophthalmologist is and should remain as the provider with the primary and ultimate responsibility for the delivery of comprehensive and continuing medical eye care including vision services to the American public.

Developed by: Committee for Health Manpower,
Secretariat for Governmental Relations

Approved: Board of Directors, 10/14/80

Statement on Behalf of the
American Academy of Ophthalmology
on Eye Care Needs of the Aging Veteran

submitted to the

House Committee on Veterans Affairs

Oversight Hearings on

VA Health Care and the Aging Veteran

July 14, 1982

The American Academy of Ophthalmology, a national professional medical organization representing 12,000 physicians who are trained in the specialty of ophthalmology (diagnosis and treatment of problems of the eyes and vision), appreciates the opportunity to comment on eye care needs of the aging veteran. The Academy, which is dedicated to helping the public maintain healthy eyes and good vision, wishes to emphasize the critical importance of planning for a comprehensive eye care service that will meet the health care needs of the aging veteran.

In a recent monograph, the VA Department of Medicine and Surgery outlined the impact that treating a higher proportion of older veterans will have on the VA health care delivery system. According to this report, disease rates will "increase with age and account for the higher utilization rates among older veterans. With an older patient population, the VA can expect increased workloads in certain areas and decreased workloads in others." (IL-10C-81-2, 11/17/81, page A-3). Of great significance, the VA projects that the number of inpatient discharges for ophthalmic-related diagnosis will increase by a dramatic 74% by the year 2000, as compared to 1980 levels. As a result, ophthalmic inpatient services will be second only to gerontologic services in terms of increased demand.

To gain some perspective on the magnitude of the 74% increase, it may be helpful to look at some current statistics. In FY 1980, inpatient discharges for veterans whose principal or associated diagnosis related to a disease or condition of the eye, excluding blindness, totaled 36,385. Of these, 19,607 were ophthalmic surgical procedures performed on veterans. The average age of these veterans was 63.1 years.

In addition to inpatient services, outpatient eye care services also must be considered. With increased utilization of techniques that can be safely performed in an ambulatory setting as well as preventive and follow-up services, there is likely to be an increased demand for outpatient eye care services. In 1980, 215,420 veterans, the average age of whom was 59.8, made outpatient visits to ophthalmology clinics. Of these veterans, 92,999 were service-connected.

With the aging of the veteran population, there is likely to be an increase in the problems and diseases of the eye associated with the aging process. Currently the major eye disorders that affect the elderly are:

- cataract: a clouding of the lens that can be treated by surgically removing the natural lens and replacing it with eyeglasses, a contact lens, or an implanted intraocular lens.
- glaucoma: an increase of pressure in the eyeball that is a major cause of blindness.
- macular degeneration: a loss of central vision caused by a breakdown of the retina.
- diabetic retinopathy: a loss of vision caused by hemorrhagging of the tiny blood vessels in the eye.

All of these eye disorders are serious. If not diagnosed and treated early, they can lead to loss of vision and thus inhibit an individual's ability to work and remain independent. Only an ophthalmologist can treat these disorders and diseases. An ophthalmologist is a medical doctor who is educated, trained, and licensed to provide total care of the eye. This care includes performing comprehensive eye examinations, prescribing corrective lenses, diagnosing diseases and disorders of the eye, and carrying out the medical and surgical procedures necessary for their treatment.

- To ensure that the eye care needs of the aging veteran population will be met, it will be necessary to estimate future needs. The Academy believes that the critical first step is to study the status of eye care currently provided by the VA. Such a study would not cost in excess of $40,000.

Unfortunately, although data on the current characteristics and activities of the VA inpatient services exist, there is a dearth of data on the VA outpatient delivery system. For the purposes of planning and meeting the needs of the older veterans, a sound and accurate data base covering both inpatient and outpatient eye care services is critical.

Although there have been studies of the VA health care system, none of them have provided comprehensive information on existing eye care services, manpower, facilities, equipment, and demand. A 1977 National Academy of Sciences review analyzed VA physicians, patients, and services in such broad categories that it was impossible to distinguish the number of ophthalmologists or ophthalmic patients and the types of ophthalmic services existing in the VA health care system. Similarly, an assessment of the role of optometry in the VA conducted in 1978 by the General Accounting Office based its analysis on a review of pertinent literature and discussions with optometrists. Actual demand and an assessment of total current eye care services being provided were not examined.

The American Academy of Ophthalmology, therefore, urges Congress to authorize a government funded, private study of existing eye care services, manpower, facilities, equipment, and demand in the VA. Such a study will provide the data needed to plan adequately for a comprehensive eye care service that will meet the needs of the aging veteran.

In addition, to ensure that veterans receive the best quality eye care, the Academy recommends to Congress the establishment of a single unified eye service in the Veterans Administration at both the Central Office and the health care facility levels. Under the current system, ophthalmology is included in the Surgical Service. Such inclusion does not recognize the fact that ophthalmology is a medical specialty as well as a surgical specialty, nor that many ophthalmic services are provided on an outpatient basis. In addition, a separate, independent optometry service exists in the VA. Since it represents only one facet of eye care, duplication of some services and clinical facilities occurs.

A unified eye service would be most cost effective and efficient. Evidence of this can be seen in similar models in both the federal and private sectors. Many health maintenance organizations are organized with some form of a unified eye service. In addition, the Uniformed Armed Services have a unified eye service under the direction of an ophthalmologist. A copy of the Academy's official policy statement on this issue is appended to this testimony and we ask that it be included in the record.

In conclusion, the American Academy of Ophthalmology believes that to meet the eye care needs of the aging veteran, a comprehensive assessment of existing eye care services must be conducted and unified eye services within the VA must be established.

Statement of the American Optometric Association
on
Vision Care of the Aging Veteran

Submitted to the
House Committee on Veterans Affairs

American Optometric Association
Washington Office
600 Maryland Avenue, S.W.
Washington, D.C. 20024

July 21, 1982
971-04

The American Optometric Association appreciates the opportunity to comment upon vision care of America's veterans; the AOA is most interested in the care of aging veterans relative to their visual needs.

Since 1972 this Association has worked with the Veterans Administration, the Congress and other related governmental agencies to further the vision care of veterans at VA medical facilities. Considerable data has been amassed, all of which demonstrate a large and still unmet need for improvements in vision care. The VA has taken positive steps towards improvements with the implementation of P.L. 94-581 which created the Optometric Service within the VA. This, coupled with staff increases at selected VA medical centers has enabled the VA to address the visual needs of our veterans. Yet much improvement needs to be accomplished.

The data currently available amply documents the contention of the American Optometric Association that there exists an unmet need for optometric care within the VA system, particularly among the aging veteran population. These data have been documented in various ways, for example:

> Several VA medical facility optometric clinics have conducted screenings, all of which have shown that the typical veteran coming to a VA medical center has a much higher than average need for optometric care. Studies have shown that approximately one-half of all

outpatients coming to a VA facility for a condition other than vision have, after being screened, an uncorrected optometric vision problem.

In 1977, a joint Task Force of the American Optometric Association and the Association of Schools and Colleges of Optometry found that by all usual standards of comparison, the VA lacked the capacity to render even minimal levels of optometric care.

The Congress recognized this problem when it authorized the creation of the Optometric Service and called for increased staff. The Congress has continued to call for staff increases. These increases, which number approximately 55 to date, were anticipated to total 100 by 1981 under the original Congressional timetable.

In 1978 the Government Accounting Office, at the request of Senator Proxmire, studied the vision care of veterans and after investigation issued a report "The Role and Use of Optometry in the VA Need Improvement." This report stated that vision care within the VA was deficient and the GAO cited the lack of staff optometrists as the principle reason.

The VA made several internal studies during 1975-1978 to determine the incidence of visual impairment among veterans. These studies utilized extrapolations from civilian data made avalible by the National Institutes of Health, Center for Health Care Statistics. All these studies projected large numbers of visually impaired veterans; numbers which could not be cared for under existing VA programs.

As a result of the above studies the VA decided to prepare a definitive study in 1978. The Office of the Controller of the VA authorized the Reports and Statistics Service to include questions pertaining to the status of the veteran's vision. This was accomplished during the annual one day census of VA patients and resulted in over 88,000 veterans being included. The result of this VA study, the largest and only definitive study made of veterans at VA facilities, showed that there was an alarmingly high percentage of veterans with vision problems. The percentage was much higher than the early estimates which were based upon civilian and National Eye Institute data.

The Aging Veteran Population

The VA's 1978 study of the approximately 88,000 veterans found that the incidence of vision problems was ten times higher than among non-veterans of the same age range. That is, even allowing for the fact that the average age of veterans is 55, an age at which vision problems are ever increasing, the veterans were found to have ten times as many optometric problems as those non-veterans of the same age. These results were issued by the Office of the Controller in March, 1979 as compiled by the Biometrics Division, Research and Biometrics Section, VA Reports and Statistics Service. They contain a wealth of information about the visual needs of veterans. And, as they are broken down by age groups, these results reveal the vision needs of the older veterans.

Therefore, it is the position of the American Optometric Association that the optometric needs of veterans are not being met and the shortfall is of considerable extent and will, since the need for optometric care increases with age, only become greater. The AOA calls to the Committee's attention this need and the ongoing concern of Members of Congress that the availability of optometric care within the VA is currently limited. The AOA stands willing to assist the VA in addressing this need.

STATEMENT FOR THE RECORD
BY

THE VETERANS OF WORLD WAR ONE
OF THE UNITED STATES OF AMERICA, INCORPORATED

PREPARED BY

WINSTON M. ROCHE'
NATIONAL COMMANDER

* * *

SUBCOMMITTEE
ON
HOSPITALS AND HEALTH CARE

JULY 14, 1982

Mr. Chairman Mottl, and Distinguished Members of this Subcommittee on Hospitals and Health Care:

Our purpose in having this presentation brought before your Committee today is not to confuse you with any Veteran problem or issue, but rather to attempt to point out in an unbaised manner, some of the things involving Veterans which possibly may not have been brought to the Committee's attention.

First of all, may I impress upon each of you that with the average age of World War One Veterans rapidly approaching the age of 87 years, that in another 7 years and 6 months, it is very likely that all or nearly all of us will be gone. Certainly then, I believe this alone should mean to every fair-minded Member of this Committee, that we, "The Veterans of the Great War that was supposed to end all wars", are entitled to be heard and be given every reasonable solution to our problems.

It is our considered opinion and hope that this Committee will:

1. Make budget recommendations or offer proper amendments to insure the much needed and proper hospital care and the implementation of 96-151, as it refers to out-patient care for the Veterans of World War One. Please keep in mind that by and large, these old Veterans (most nearly 87 or older) really need a continuation of Veteran Hospital Care to which they have been accustomed and certainly deserve. Oppose any and all budget cuts which obviously would reduce any Veteran Hospital Staff. This alone we believe would be highly detrimental to Veterans in need

of the splendid care they have had in the past.

2. Give very careful consideration and approval to the concept that Veterans of World War One be continued in the range of priority #2 when applying for admission to a Veterans Hospital for medical care. Always remember that expected life expectany of only about 7 years and 6 months remain for us.
3. Vigorously oppose the closing of any of the Veteran Hospitals or Medical Centers. All of them are needed today and will be needed even more in the years ahead as the young Veterans of today become the old Veterans of tomorrow.
4. Unalterably oppose in any way, the diminution of the continually needed health care services for our Veterans of World War One.
5. Oppose any proposal to convert any of our great Veteran Administration Hospitals into "Public Medicare" Institutions. Our organization of World War One Veterans definitely believe that such a conversion at this time would be a gigantic mistake and would represent a disservice to all the living Veterans of all wars.

The October 1, 1981, law which removed the $300 burial benefit for all non-service connected Veterans, has had a catastrophic effect upon all areas of our Country. Cities and Counties are faced with the task of finding the funds to provide an honorable burial for the bodies of unclaimed Veterans. The Veterans groups buried three unclaimed Veterans bodies, with privately donated funds on Monday, February 1982, in Los Angeles, California. There was also one unclaimed Veteran's body buried by Los Angeles County.

In our opinion, the above law was not thoroughly researched before it was recommended to be included in the VA fund cuts. There are, at the present time, two Bills before the Congress, one in the House authored by Congressman Augustus Hawkins, H.R. 5369, and one in the Senate introduced by Senator Alan Cranston, S. 2048. We urge the prompt approval of these two vitally necessary Bills.

We view with alarms, the trend, triggered by the curtailment of funds available to the VA; to the restructuring of the entire VA Health Care System, it's benefits, and Health Care entitlements for the Veterans of America. It comes down to a matter of, "Money v.s. Commitment".

We respectfully urge the Subcommittee on Hospital and Health Care, to stand firm in your historic commitment to the welfare of America's Veterans.

We thank you for giving us the opportunity to state our case.

WINSTON M. ROCHE'
NATIONAL COMMANDER

Veterans of World War One
of the U.S.A., Inc.

Best Available Copy